

REPORT DOCUMENTATION PAGEForm Approved
OMB No. 0704-0188

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1. REPORT DATE (DD-MM-YYYY)

June 2005

2. REPORT TYPE

Final Report

3. DATES COVERED (From - To)

July 2004 to July 2005

4. TITLE AND SUBTITLE

A Qualitative Analysis of Resource Sharing Agreements between
Naval Hospital Great Lakes and North Chicago Veterans Affairs Medical Center:
The Iron Triangle Theory of Healthcare Integration

5a. CONTRACT NUMBER**5b. GRANT NUMBER****5c. PROGRAM ELEMENT NUMBER****6. AUTHOR(S)**

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5d. PROJECT NUMBER**5e. TASK NUMBER****5f. WORK UNIT NUMBER****7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)**

Naval Hospital Great Lakes
3001A Sixth Street
Great Lakes, IL 60088

8. PERFORMING ORGANIZATION REPORT NUMBER**9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)**

US Army Medical Department Center and School
BLDG 2841 MCCS-HRA (Army-Baylor Program in Healthcare Administration)
3151 Scott Road, Suite 1411
Fort Sam Houston, TX 78234-6135

10. SPONSOR/MONITOR'S ACRONYM(S)**11. SPONSOR/MONITOR'S REPORT NUMBER(S)**

32-05

12. DISTRIBUTION / AVAILABILITY STATEMENT

Approved for public release; distribution is unlimited

13. SUPPLEMENTARY NOTES**14. ABSTRACT**

The Naval Hospital Great Lakes (NHGL) and North Chicago Veterans Affairs Medical Center (NCVAMC) form strategic alliances through resource sharing agreements. This research posits that the successful integration of healthcare system components, such as resource sharing agreements, occurs when improvements to cost, quality, and access are mutual, and the outcomes meet organizational expectations. The researcher calls this proposition the Iron Triangle Theory of Healthcare Integration, and uses it to qualitatively analyze the resource sharing agreements between NHGL and NCVAMC. The research methods of situational analysis, informal interviews, and document evaluation objectively define the variables of this qualitative research. The results provide a calculated explanation of the delta between the theoretical intent of resource sharing agreements and the outcome from the actual implementation of the integration.

15. SUBJECT TERMS

resource sharing agreements, strategic alliances, integration, cost, quality, access, organizational expectations, Iron Triangle Theory of Healthcare Integration, document evaluation

16. SECURITY CLASSIFICATION OF:**a. REPORT**

U

b. ABSTRACT

U

c. THIS PAGE

U

17. LIMITATION OF ABSTRACT

UU

18. NUMBER OF PAGES

89

19a. NAME OF RESPONSIBLE PERSON

Education Technician

19b. TELEPHONE NUMBER (include area code)

(210) 221-6443

Running Head: A QUALITATIVE ANALYSIS OF RESOURCE SHARING
AGREEMENTS

A Qualitative Analysis of Resource Sharing Agreements between
Naval Hospital Great Lakes and North Chicago Veterans Affairs Medical Center:
The Iron Triangle Theory of Healthcare Integration

Presented to

Lieutenant Colonel Nicholas Coppola, USA, MSC, FACHE

In Partial Fulfillment of the Requirements for

A Master in Health Administration

By

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May 19, 2005

20060315 104

Disclosure as called for by Navy Regulation .

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Acknowledgments

I give special thanks to my preceptor and mentor, Captain John C. Olsen, MC, USN, for his steadfast guidance, endless encouragement and comical sarcasm. Dr. Olsen's astute advice and intellectual discourse made the difference in creating an excellent residency year for me.

On a personal note, I appreciate my parents for their everlasting support and for always making my education their first priority while I was growing up.

I owe my enthusiasm and perseverance throughout this process to my husband, Dr. Michael Hjelkrem. I am thankful for his unmatched wit, endless understanding, and constant affection. His clinical perspective keeps me focused on my mission; to improve healthcare organizations in order to make patients healthier and happier.

Abstract

The Naval Hospital Great Lakes (NHGL) and North Chicago Veterans Affairs Medical Center (NCVAMC) form strategic alliances through resource sharing agreements. This research posits that the successful integration of healthcare system components, such as resource sharing agreements, occurs when improvements to cost, quality, and access are mutual, and the outcomes meet organizational expectations. The researcher calls this proposition the Iron Triangle Theory of Healthcare Integration, and uses it to qualitatively analyze the resource sharing agreements between NHGL and NCVAMC. The research methods of situational analysis, informal interviews, and document evaluation objectively define the variables of this qualitative research. The results provide a calculated explanation of the delta between the theoretical intent of resource sharing agreements and the outcome from the actual implementation of the integration.

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Introduction

While hospital mergers boomed in the 1990's, and then fell off, there appears to be an upswing in hospital mergers today (Galloro & Evans, 2005; Zuckerman & D'Aunno, 1990). Where civilian mergers are common, federal mergers are still a novelty. The concept of joint federal healthcare facilities becomes more attractive as the roles of today's military forces expand. The priorities of the modern military healthcare system include: training providers for operational readiness, ensuring quality, economical health services to beneficiaries, foraging *One Navy Medicine* among Active Duty, Reserve and Civilian staff, and shaping tomorrow's force with the appropriate mix of health professionals (Arthur, 2005).

Much like their civilian counterparts, federal health facilities feel the economic strain imposed by the proliferation of health technology, an aging population, and the rising cost of healthcare and pharmaceuticals. In 2001, responding to this developing crisis, President George W. Bush issued Executive Order 13214, creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. A call to action, the President's Task Force criticized the organizational and facilities management of healthcare systems within the Department of Defense (DoD) and Department of Veterans Affairs (VA) and warned of their demise if they stayed in their static state (Presidential Task Force, 2003). This warning shot elicited the integration of product lines at North Chicago VA Medical Center and Naval Hospital Great Lakes, known as resource sharing agreements. The subject of this research, the outcomes of these agreements, could provide significant improvements to the cost, quality, and access to healthcare for Department of Defense and VA beneficiaries.

Pressured to do more with less, Congress sees potential the economies of scale in joint Federal medical commands like the one proposed between the conceptual Federal Ambulatory Care Clinic (FACC), a healthcare system jointly operated by the Naval Hospital Great Lakes and North Chicago VA Medical Center to treat VA and DoD beneficiaries. Congressman Mark Kirk (R-IL) reflects this intent when he states, "Four congressional committees endorsed this kind of sharing agreement and encouraged the construction of a jointly operated federal hospital to serve both veterans and recruits and save taxpayer dollars by sharing certain common resources" (Kirk, 2001). At a minimum cost of \$100 million, the Federal Ambulatory Care Clinic will be the largest scale merger of the DoD/VA healthcare systems in history (Department of Veterans Affairs, 2004). Following the recommendations of the Capital Asset Realignment for Enhanced Services (CARES) study, a strategic plan for streamlining the VA healthcare system in order to increase cost savings and improve Veterans' healthcare, politicians are watching the outcome of this integration to determine the feasibility of similar federal healthcare agreements in their districts.

Resource sharing agreements, the locally developed integration of medical services between the DoD and VA, often cause a crisis when the resulting integration falls short of the expectations of Naval Hospital Great Lakes and the North Chicago VA Medical Center. Paramount to the success of these resource sharing agreements is a well-thought out business plan by these two delivery systems to integrate complementary parts of their separate healthcare systems. In order to make the outcomes of future resource sharing agreements more predictable and mutually beneficial, the two federal organizations should conduct a qualitative analysis of the resource sharing agreements,

using the research methods of situational analysis of their organizations, informal interviews of staff members, and document reviews (Pesnell, 2004).

An organizational appreciation for the business process of developing resource sharing agreements would minimize the many crises and miscommunications common to multiple resource sharing agreements in the past between North Chicago VA Medical Center and Naval Hospital Great Lakes. Analysis of the entire Federal Ambulatory Care Center merger falls outside the scope of this thesis. However, a qualitative study of the two historical resource sharing agreements, for the development of an Inpatient Mental Health Clinic and a Blood Donor Processing Center, within the context of a situational analysis demonstrates that integrations that improve cost, quality, and access represent the best strategy for future DoD/VA joint endeavors.

Conditions that Prompted the Study

On a national level, any consolidation, merger, integration, or acquisition of a single hospital product line to an entire healthcare system ends disastrously when the integration strategy is haphazard and the resultant product disappointing. The sum of the parts being merged should increase the quality of care and access to care, while diminishing the cost for the partnering organizations. The intent of the Iron Triangle Theory of Healthcare Integration is to begin filling the gap in the literature and explain why some integrations are positive, while others are negative. A positive integration occurs when the expected outcomes of both organizations are achieved. A negative integration occurs when its result is untrue to the expected outcomes of both organizations. Exploring the proposition of the Iron Triangle Theory of Healthcare Integration requires a situational analysis of the two integrating organizations as a

foundation, supported by informal interviews with staff members, and followed by document review of resource sharing agreements between Naval Hospital Great Lake and North Chicago VA Medical Center. To ensure the success of the full integration of Naval Hospital Great Lakes and North Chicago VA Medical Center, also known as the Federal Ambulatory Care Clinic, requires an understanding of the foundering of past resource sharing agreements based on tenets of the Iron Triangle Theory of Integration.

Problem Statement

The Naval Hospital Great Lakes and the North Chicago VA Medical Center can improve their piecemeal development process of resource sharing agreements and attain dependable outcomes if they implement the Iron Triangle Theory of Healthcare Integration to improve cost, quality, and access for both organizations. Conducting a situational analysis of the internal and external environment provides an awareness of organizational expectations and cultural norms integral to consider when planning successful resource sharing agreements. Failure to improve the resource sharing agreement strategy will lead to continued knee-jerk reactions to more systematic integration disagreements, a strained relationship between the Naval Hospital Great Lakes and North Chicago VA Medical Center, and a discontinuity between the strategic goals of the integration and actual implementation of the resource sharing agreement.

Definitions

Before delving into this research, the definitions of some key terms are vital. An organization refers to a group of people who come together to pursue a specific purpose (Shortell & Kaluzny, 2000). Consolidation, integration, merger, and acquisition are used interchangeably throughout the literature. For the purposes of this thesis, and as

demonstrated by the following definition, the term integration refers to the strategic alliance that forms between Naval Hospital Great Lakes and the North Chicago VA Medical Center. Zuckerman and Spallina (2001) state integration:

May achieve economies of scale, this is not its sole purpose. Integration is used to tap the synergies inherent in the greater mass and complementary expertise and capabilities of multiple system members. Integration typically applies to clinical programs and regional network development (either as managed care contracting or specialty-specific relationship building strategy). It frequently focuses on building joint programs in markets to better satisfy community needs, physician practice objectives, and system strategy and growth objectives. Because integration can be politically sensitive with the medical staff, physician driven initiatives are the most successful. And although the ultimate form of integration is consolidation, this by no means is the only form it can take (p. 12).

In accordance with the definition of integration, resource sharing agreements achieve economies of scale while meeting the needs of DoD/VA beneficiaries, provide continued medical education to physicians, and fulfill the growth strategies of both federal facilities. Integrations lead to economies of scale because organizations combine their resources to produce a service that impacts more patients at a lower cost than if they were to produce that service individually. For example, the Background section will discuss economies of scale achieved when Naval Hospital Great Lakes and North Chicago VA Medical Center jointly operated a CATSCAN.

Integrations are minimal to extensive in nature; they can involve a single product line or envelope the joining of governance boards, organizational structures, and cultures

(Zuckerman and Spallina, 2001). Integrations occur between all types of healthcare players such as: hospitals and physician groups, hospitals and health maintenance organizations, and between hospitals, physicians and agencies of the federal government (Shortell, 1988; Kaluzny, Morrissey, & McKinney, 1990). A resource sharing agreement between Naval Hospital Great Lakes and North Chicago VA Medical Center forms a health network, or “a contractual arrangement...that provides an array of health services to the community” (Shortell & Kaluzny, 2000). When these two organizations form a health network they serve beneficiaries in the DoD and VA communities.

Meyer (1982, p. 517) says integration often occurs as a result of environmental jolts which are “relatively abrupt, major, and often qualitative changes in an environment that threatens organizational survival.” Four examples of environmental jolts, the aging veteran population and the Government Accounting Office’s 2001 report that threatened to close North Chicago VA Medical Center, caused North Chicago VA Medical Center to consider a strategic alliance. Similarly, the aging facilities and political pressure to contain costs led Naval Hospital Great Lakes to consider integration.

The Theory: Tenets of the Iron Triangle Theory of Healthcare Integration

A good organizational model can simplify the complexities of integration between two healthcare institutions. By definition, Kissick’s theory of the Iron Triangle says that a balance between cost, quality and access constitutes an ideal healthcare model (1994). In an *Executive Summary on Healthcare*, the United States Department of Justice summarizes the Iron Triangle Theory; “in equilibrium, increasing the performance of the healthcare system along any one of these dimensions can compromise one or both of the other dimensions, regardless of the amount that is spent on healthcare” (United States

Department of Justice, 2005). Healthcare integrations are best described in terms of improving cost, quality, and access because they are the primary expected outcomes for most strategic alliances. Shortell and Kaluzny (2000) confirm this assumption:

The strategic intent of alliances can also be observed in terms of their expected outcomes. An emphasis on expected alliance outcomes is relevant for several reasons: The success of an alliance will generally be defined by the degree to which the desired outcomes are achieved; some performance outcomes may be largely incompatible with others; and one alliance partner's perception of the expected outcome may not be shared by the other partners (p. 34).

As defined earlier, the difference between a positive and negative integration depends on whether it meets expected outcomes of the organization. In accordance with this citation, results of the resource sharing agreement document review will demonstrate that the expected outcomes of organizations are sometimes incompatible.

Cost is defined as "what it costs the provider to produce a service" (Shi & Singh, 2001). The literature review later reveals that cost, referring to both savings and building of equity, is the leading expected outcome of integrations between organizations. "The first and most basic expected outcome refers to the financial performance and addresses the issue of whether the alliance is primarily conceived for cost reduction or revenue enhancement" (Shortell & Kaluzny, 2000). Cost reduction typically requires "a combining of similar resources requiring relatively less active coordination, given that there is a pooled interdependence among the partners" (Thompson, 1967, p. 8). Meanwhile revenue enhancement requires more coordination and interdependence between the organizations (Shortell & Kaluzny, 2000).

The second apex of the Iron Triangle and another common expected outcome of integration is an improvement in quality. Prahalad and Hamel (1990) and Zajac (1991) reinforce this when they state, "Another way of classifying the intent [expected outcome] of an alliance is the degree to which the alliance seeks to enhance outcomes such as innovation, organizational learning, and quality." The Institute of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Shi & Singh, 2001). An organization's reputation for quality patient care may be enhanced or damaged by the association with another organization when the alliance fails to deliver the expected level of quality.

The third apex of the triangle is access, which means "the ability to obtain needed, affordable, convenient, acceptable and effective personal health services in a timely manner" (Shi & Singh, 2001). Given the growing demand for healthcare technology and the rising number of uninsured, enhanced access to healthcare is a commonly expected outcome of integration. The Presidential Task Force comments on the importance of access: "Access to healthcare is a growing concern for many Americans and the availability of health services provided through VA and DoD to beneficiaries is an increasingly important resource. For some veterans, VA may be their only healthcare provider" (2003, p. 23). Improving access through integration can include but are not limited to extending clinic hours, opening more clinics within the community, and combining the resources of organizations to develop new product lines.

This thesis extrapolates upon the Iron Triangle theory in order to analyze the difference between positive and negative integration of healthcare entities. Unlike the

original theory, The Iron Triangle Theory of Healthcare Integration uses two overlapping isosceles triangles to represent the balance both healthcare systems are trying to achieve among cost, quality, and access. In Figure 1 notice that each hospital is located on one side of the model and the apexes of the larger triangle point to either side of the model. The orientation of the large triangle's three apexes depends on the expected outcome each healthcare institute anticipates for cost, quality, and access. Successful integration, discussed later in the Literature Review, is determined by attaining each of the healthcare institute's expected outcomes that are based on organizational desires, cultural norms, and corporate history.

The researcher uses a situational analysis of North Chicago VA Medical Center and Naval Hospital Great Lakes along with interviews of leaders from these organizations to determine the expected outcomes of each institution. In Figure 1, the qualitative analysis of each institution reveals North Chicago Veterans Affairs Medical Center's expected outcome places emphasis on quality and access, while Naval Hospital Great Lakes looks primarily at cost. At the commencement of integration of services, both healthcare institutions are located in the center of the triangles. A positive integration occurs when both hospitals improve cost, quality, and access and the arrows move toward (+1) on the large, green apexes. A negative integration develops when cost, quality, or access is degraded for either institution, represented by the arrows moving towards (-1) on the red apexes as a result of the integration.

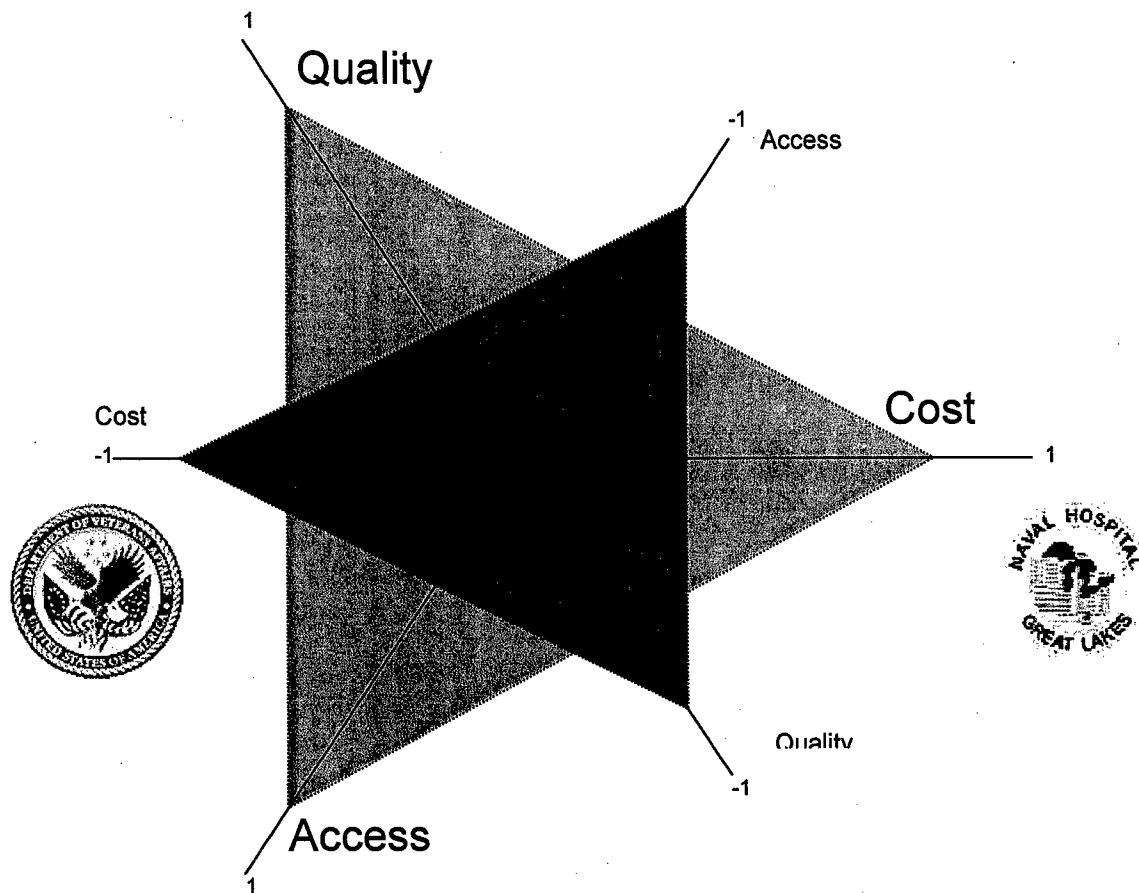


Figure 1. Qualitative analysis of each institution reveals North Chicago Veterans Affairs Medical Center's expected outcome places emphasis on quality and access, while Naval Hospital Great Lakes looks primarily at cost.

In order to more completely consider this theory on its merits, other nuanced variations of this model may be helpful. First, if both organizations share expected outcomes for cost, quality, and access this scenario looks like Figure 2. This situation creates a positive integration because the objective of both organizations is to improve cost, quality, and access. Therefore, the arrows move into the green apexes from the center at universal zero and no deficiency occurs that would place either institution into the red apexes.

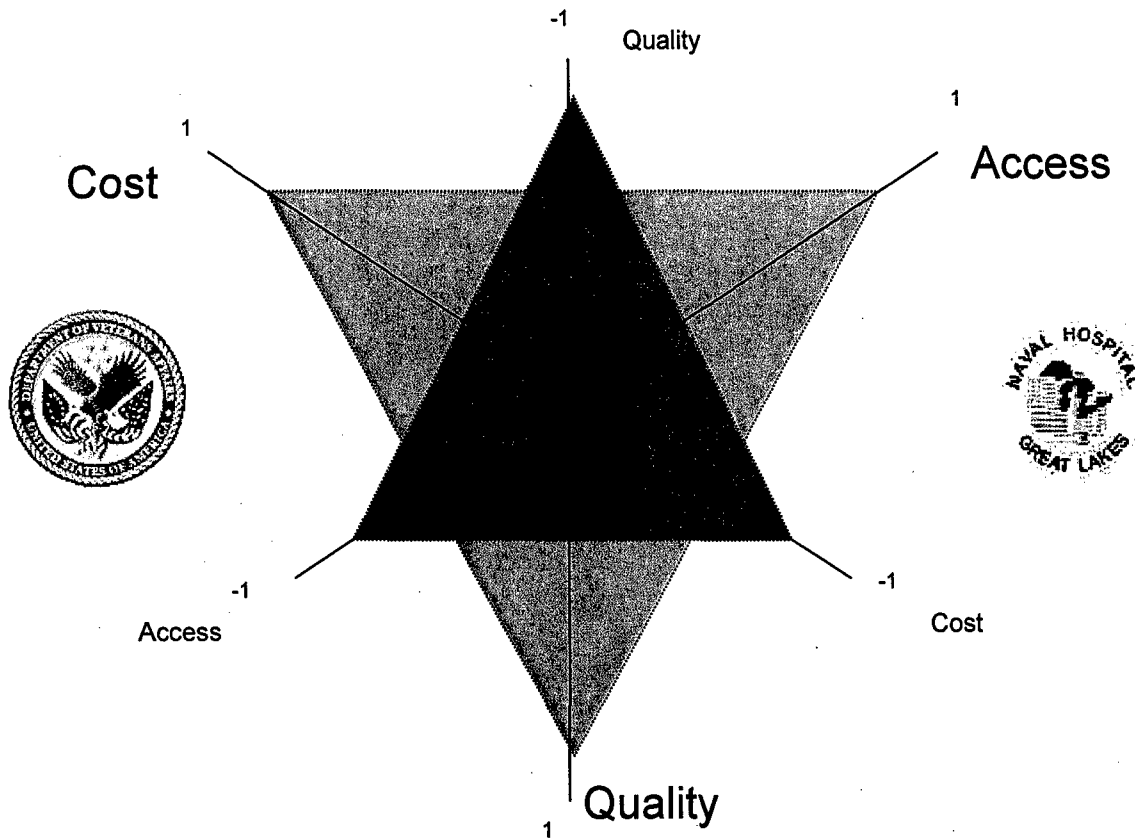


Figure 2. When both organizations share expected outcomes for cost, quality, or access.

Figure 3 represents the second scenario when both institutions share the same expected outcomes, but neglect others. Since both institutions focus on cost, and access the arrows move toward (+1) on the large, green apexes. However, neither institution addresses quality so the arrow moves toward (-1) on the apex of the smaller, red triangle. This results in a negative integration because both institutions neglect quality and, therefore, an imbalance results in the Iron Triangle. Finally, when two institutions already focus and balance cost, quality, and access then integration is unnecessary, but possible.

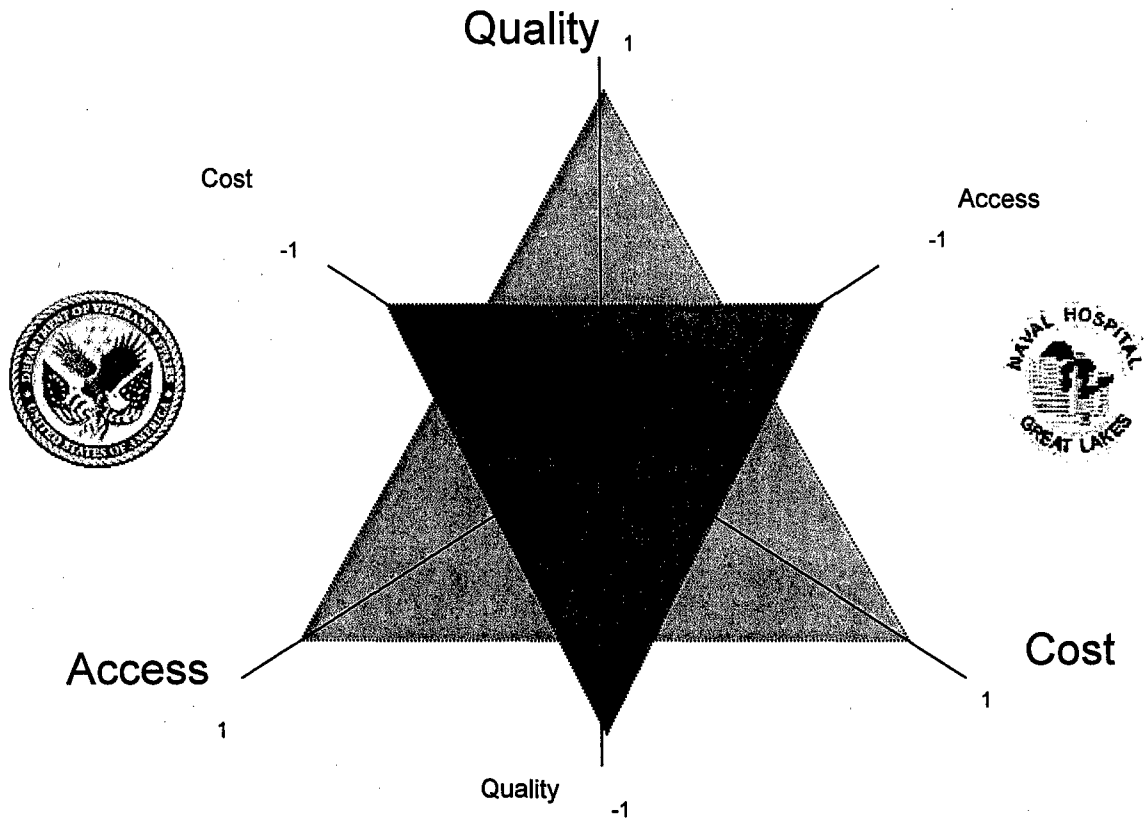


Figure 3. Represents the scenario when the both institutions share the same expected outcomes, while neglecting others.

Proposition

The progressive integration of healthcare system components, such as those that start with resource sharing agreements, occur positively when the improvements to cost, quality, and access are mutual, and the outcomes meet organizational expectations of the integrating healthcare systems.

The antithesis of this proposition is that the negative integration of healthcare systems occurs when the improvements to cost, quality, and access are mutual, and organizational expectations are met.

Assumptions

A balance of cost, quality, and access proves necessary to maintain a healthcare system (Kissick, 1994). As a result of an environmental jolt, healthcare organizations merge product lines or even entire systems when they discover an imbalance of this tripod within their separate systems. Successful integration occurs only when the sum of the combined entities improves the balance of cost, quality, and access for the organizations involved. From product lines to entire systems, the integration of two organizations should be driven by a common vision. Finally, when two organizations form a resource sharing agreement they must articulate the details of implementation, utilization, and measurable goals in order to avoid miscommunications and conflicts.

Literature Review

Following a literature review conducted at Naval Hospital Great Lakes medical library of OVID medical/psychology journals and LEXUS/NEXUS the author is unaware of any studies that specifically analyze integration, such as resource sharing agreements, between Naval Hospital Great Lakes and North Chicago VA Medical Center. However, a review of the relevant literature on integration of hospital product lines and whole healthcare networks revealed an explanation of the emergence of strategic alliances, their structure, and their evolution over time. This literature review looked at academic, peer reviewed journals, as well as, textbooks for its theoretical framework. Additionally, the researcher consulted niche trade journals for the application of these theories in modern healthcare systems.

The researcher studied the field of organizational behavior and relevant literature on qualitative analysis of strategic alliances, like resource sharing agreements. The

following four themes emerged in the literature review on healthcare system integration. First, often too much emphasis is placed on the bottom line when planning the integration of healthcare systems (Bradford & Duncan, 2000; Hoffman, 1996). Second, many organizations lack a common vision to drive their integration (Lumsdon, 1996; Hansen, 1996; Bradford & Duncan, 2000). Third, getting passed historical stigmas and facilitating the melding of cultures requires critical analysis of organizational norms, expectations, and public perceptions (Taylor, 2005; Bradford & Duncan, 2000; Harrigan, 1985). Fourth, organizations should never rely on integration as a panacea to obtain better facilities, technology, capital, and assets (Taylor, 2005; Galloro & Evans, 2005; Shortell & Kaluzny, 2000; Zajac, Golden & Shortell, 1991). Healthcare systems integration with respect to antitrust law and charitable status will not be addressed, since these concerns do not affect federal institutions like Naval Hospital Great Lakes and North Chicago VA Medical Center.

The first theme found in the literature review argues that organizations place too much emphasis on the bottom line in pursuing integration. Bradford and Duncan state, "When businesspeople talk about strategy [for integration], often they talk about the 'hard side' of strategy—the market and competitive aspects. The concentration is usually on the quantitative and analytical. But there's another, equally important side, a softer side." When considering the strengths and weaknesses of a merger, Bradford and Duncan recommend considering the following: "competitive advantages, customer satisfaction, marketing/sales performance, capital resources, costs/pricing, innovation, organizational design, internal systems, management, human resources, and corporate

culture” (2000). Only capital resources and cost/pricing solely refer to the financial, hard side, while the other considerations are on the softer side.

Many trade journals warn that while the financial benefits of integration may look attractive on paper, they often fail because the merging cultures clash, the values of the organizations conflict, and information technology lacks compatibility. Paul Hoffman comments:

Too often, however, the conventional due diligence process preceding merger and acquisitions concentrates almost exclusively on financial, legal, and regulatory matters. Disregarded, or inadequately are considered, are differences in corporate cultures, including organizational vision and values. The possibility of serious future conflict is likely unless existing and potential incompatibilities are thoroughly evaluated (1996. p. 12).

Moving past the financial statements and addressing other incompatibilities proves paramount to attaining the successful integration of organizations. Trade journals, like *Modern Healthcare*, cite numerous examples where integrations abort when the hard side of strategy upstages the softer side of strategy, like culture, vision, and values.

A second theme in the literature review recognized the importance of organizations sharing a common vision for their integration. Throughout the integration process a common vision must be communicated between the organizations. “The vision should provide the frame for decision making and a basis for inspired coordinated action” (Shortell & Kaluzny. 2000). The literature demonstrated that many organizations fail to communicate a common vision, because they assume that they share a common vision since they agree to integrate. For example, the document review will indicate that even

though North Chicago VA Medical Center and Naval Hospital Great Lakes signed the same resource sharing agreement they held separate visions for the inpatient mental health clinic; the former organization intended to generate revenue, while the latter wanted to reduce costs. Jim Hudack, a health executive for Anderson Consulting comments, "I'm surprised at how many people enter into mergers and alliances without a clear understanding of why they're doing it. Is it cost cutting? Removing excess capacity? Gaining some core capability you didn't have before? People don't specify. Or they lose track of what it was all about" (Lumsdon, 1996). Bill Corley, the veteran of a failed merger among community hospitals in Indianapolis states: "The dreams of both partners must coincide, or you're destined for failure" (Lumsdon, 1996). A lack of common vision to steer integration is like driving a car without a destination.

Merging toward a common vision cannot be assumed by the organization; strategic management helps implement the common vision throughout the integration process. Strategic management "is an externally oriented philosophy of managing an organization towards a future state that: attempts to orchestrate a fit between external and internal environments" (Lafrance, personal communication, September 30, 2003). Both federal organizations must utilize strategic management in order to achieve a common vision and successfully implement a resource sharing agreement. "Medical groups that achieve superior operational and financial performance frequently have leaders who practice effective governance and take time to conduct strategic planning" (Hansen, 2003).

An adaptive response to environmental change, resource sharing agreements between Naval Hospital Great Lakes and North Chicago VA Medical Center create

strategic alliances because they are “formal arrangements between two...organizations for purposes of ongoing cooperation and mutual gain” (Shortell & Kaluzny, 2000).

Specifically, the integration of Naval Hospital Great Lakes and the North Chicago VA Medical Center is a trading alliance because they “bring together organizations seeking to contribute different resources (Nielson, 1986)” (Shortell & Kaluzny, 2000). The primary tool used in implementing a strategic alliance is a strategic plan, such as resource sharing agreement. Bradford and Duncan state,

A good strategic plan is really a management tool. Strategy takes a grand vision and turns it into something useful. It should be a simple statement of the few things we really need to focus on to bring success as we define it. Simplified strategic planning is specific and detailed, but not excessively so. The idea is to build a good plan that works, is easy to understand, and is comprehensive but not ponderous (2000, p. 10).

A document review of the two resource sharing agreements between Naval Hospital Great Lakes and North Chicago VA Medical Center, later in this thesis, will gauge whether the agreements are specific enough to ensure accountability and easy interpretation by both organizations.

The third theme of the literature review addressed the process of implementing integration and getting past historical stigmas between the organizations while facilitating their assimilation of cultures, and the management of public perception. The president of an Illinois consulting firm, Linda Hyden summarizes that the hospital's greatest challenge in implementing integration is developing a common culture going forward, “We are

taking the best of both but trying to develop something new. That's where our success will lie" (Taylor, 2005, p. 24).

Staff physicians and executives need to discuss and preserve their cultures together, develop a common mission, and educate their staff and community on what to expect during and after the transition. "It's important that your culture be aligned with your strategy, because one of the critical things in any company is the motivation of employees" (Bradford & Duncan, 2000, p. 170). Harrigan (1985) argues that integration by nature is risky because of public perception, the cultures of the two merging organizations, and the dependence on continual cooperation.

In addition to merging cultures, public perception must also be managed. Integration may fail if the public perceives their interests are being ignored. "Public opinion should be considered before moving ahead with significant plans that will affect the public" (Taylor, 2005). Managing public perception provides the basis to attaining three of the important soft considerations of integration: competitive advantage, customer satisfaction, and marketing/sales performance (Bradford & Duncan, 2000).

Finally, touching on the first theme, measuring the success of integration includes evaluating opportunities for innovation, learning about new markets, and not just looking at the affect on the bottom line of the involved organizations. The literature review warned against seeking integration as a panacea to obtain better facilities, technology, capital, and assets. Integration is not a cure-all. *Modern Healthcare* cites most healthcare system integration occurs to gain better access to capital, technology and a competitive position in the market (Taylor, 2005). Still, within the healthcare industry, strategic alliances more often fail than succeed (Galloro & Evans, 2005). When

measuring the risks of strategic alliances it, "should be balanced with an assessment of the expected return or benefit of the alliance...in terms of improved financial performance, innovation, organizational learning, and the opportunity cost of not engaging in a strategic alliance" (Shortell & Kaluzny, 2000). The same authors stress that while financial performance is important, it should not have the greatest emphasis when measuring the success of a strategic alliance. "For example, innovation may be a driving force behind strategic alliances, and more generally alliances may be viewed as a desirable way for organizations to learn about new markets, services, and ways of doing business" (Zajac, Golden & Shortell, 1991). Success is also measured by improvements to quality and access, although it is more subjective than improvements to the bottom line.

Measuring the success of integration depends on having specified goals to use as benchmarks.

The mission statement as a declaration is a great communications tool, but real accomplishment comes from specifics. Goals define the routine, the day-to-day business. Goals are the statements of continuing intended results that are both necessary and sufficient to your concept of success (Shortell & Kaluzny, 2000, p. 34).

Goals can be used as a quantitative means of attaining qualitative ends, like successful integration of two healthcare organizations. With regard to the Iron Triangle Theory of Healthcare Integration, setting specific goals within a resource sharing agreement is necessary to measure an improvement to the balance of cost, quality, and access. Looking at Figure 1, as a result of the integration, reaching specific goals results in

movement of the arrows to the green apexes (+1) on the large triangle. Conversely, a lack of specified goals in the resource sharing agreement or a failure to achieve the goals results in movement of the arrows to the red apexes (-1).

Tenets of the Integration Process: Emergence, Transition, Maturity, and Critical Crossroads

Table 1 shows the four steps of integration; Emergence, Transition, Maturity and Critical Crossroads that make up the Alliance Process (Shortell & Kaluzny, 2000). During the Emergence step, previous Naval Hospital Great Lakes and North Chicago VA Medical Center resource sharing agreements established the current expected outcomes, trust, and group dynamics between the organizations. Currently, the Naval Hospital Great Lakes and North Chicago VA Medical Center alliance face the Transition step.

Table 1

A Life Cycle Model of Organizational Alliances in Healthcare

Stage	Description	Example
Emergence	Environment poses threat to	Define purposes of the
	and uncertainty about	alliance
	valued resources	Develop membership
	Organizations share	criteria
	ideologies and similar	
	dependencies	
		Hire or form a
Transition	Motivation to achieve	management

	purposes of the alliance	group
		Establish mechanisms
	Increased independence on	for
	alliance for valued resources	coordination and control
Maturity	Willingness to put alliance	Attain stated objectives
	interests first	Sustain member
	Members receive benefits	commitment
	from previous investments	
Critical		
Crossroads	Increased centralization and	Manage decisions about
	dependence on alliance	future of the alliance
	motivates members to	
	seek hierarchy or	
	withdraw from alliance	

Note. From *Healthcare Management: Organizational Design and Behavior*, 4th Ed. by Shortell, S. M. & Kaluzny, A. D., 2000, p. 318, Albany, NY: Delmar, Thomson

Learning

Gathering knowledge about the organizational expectations, cultural norms and corporate history occurs during the Emergence step of the Alliance Process.

In the first stage, environmental threats [jolts], opportunities, and uncertainties lead organizations with similar ideologies and dependencies to seek out each other....Perceptions of what each exchange partner seeks also emerge more clearly, enabling the more precise identification of similarities and differences that can form the basis for mutually beneficial exchange (Shortell & Kaluzny, 2000, p. 35).

Furthermore, this is the stage when trust between the organizations forms and, "can set a precedent for future exchange and provide information through which a firm can learn about the expected behavior of its partner. During this phase, initial relational exchange norms are being forged and commitments tested in small but important ways to determine credibility" (Macneil, 1983). In summary, during the Emergence stage, the organizations communicate their expected outcomes. The development of trust and group dynamics begins here.

The Transition step "establishes mechanisms for coordination, control, and decision making. The transition [step] may be rocky because...organizations are reluctant to grant authority to others or sacrifice their own autonomy" (Shortell & Kaluzny, 2000, p. 37). During this step, it is necessary to select a governance model, and the presence of trust between the organizations becomes paramount (Shortell & Kaluzny, 2000). The section on History of Resource Sharing Agreements between Naval Hospital Great Lakes and North Chicago VA Medical Center looks at the status of these organizations in the Transition step.

Background

A Tale of Two Hospitals

While North Chicago Veterans Affairs Medical Center and Naval Hospital Great Lakes have always shared resources, like laundry services and CATSCANS, marriage of the two facilities became a viable option as politics forced both facilities to consider their long-term ability to meet the needs of their beneficiaries. Congress considered closing the North Chicago VA Medical Center after a Government Accounting Office report declared it to be the most costly facility in the entire VA system (GAO, 2000). The intended closure would have downsized the North Chicago VA Medical Center into a skilled nursing facility and mental health facility. The GAO report led Congress to request a financial assessment and strategic plan for the entire VA healthcare system, which became known as the Capital Asset Realignment for Enhanced Services (CARES). At the same time Naval Hospital Great Lakes hired a contractor, SRA International, Inc., to evaluate their options to update their aging medical facilities.

Capital Asset Realignment for Enhanced Services

Capital Asset Realignment for Enhanced Services, announced on May 7, 2004, by former Secretary of Veterans Affairs Anthony J. Principi, is a strategic plan for the Veterans Association Healthcare System. It marked a three-year review of veterans' current healthcare needs and recommendations for meeting those needs in the future (Department of Veterans Affairs, 2004). Begun in October 2000 by the Department of Veterans Affairs, the goal of the CARES process is "Planning now for veterans' future healthcare needs" and realigning their facilities to meet those needs (CARES, CH 5 SDO). Anthony Principi states:

VA can effectively manage and implement an important program such as CARES and deliver results for veterans. The results may come with difficult choices. As

VA enters the process of making these choices in communities across the country, it is important to remember the broad outcomes it seeks—more effective use of VA resources to provide more care, to more veterans in places where veterans need it most (News Release, August 2003).

The two phases of the CARES process are phase I, a pilot study to look at resource management at North Chicago VA Medical Center, and phase II, a resource management analysis of the entire VA healthcare system. The first pilot study, conducted at Veteran Integrated Service Network (VISN)12, focuses on forming more resource sharing agreements between the Department of Veterans Affairs and Department of Defense, specifically the North Chicago VA Medical Center and Naval Hospital Great Lakes. The primary purpose of CARES is to improve the access, quality, and cost of healthcare delivered to veterans. The VA states:

Once the CARES process is completed, VA will be able to provide accessible care to more veterans in the most convenient and appropriate setting. Any savings that result from the CARES process will be used to provide higher quality care and more services to more veterans (News Release, Aug 2003).

Paralyzed by an archaic inpatient centered infrastructure, the VA is in the process of redesigning their facilities to meet the requirements of new outpatient medical treatments and expanding or closing facilities based on changes in the geographic distribution of veterans. The Government Accounting Office (2000) found that “the VA was spending a million dollars a day on unneeded or unused facilities” (News Release, 2003). Updating facilities in order to reduces high maintenance costs, another major issue identified by the Government Accounting Office (2000).

In 2001, the Department of Veterans Affairs hired Booz-Allen & Hamilton to spearhead CARES Phase I. Booz-Allen & Hamilton announced three Service Delivery Options for each of the market areas within VISN 12. While each option gives different recommendations for the VA's Chicago City Health Care system, the recommendations for North Chicago VA Medical Center and Naval Hospital Great Lakes resource sharing are consistent across all options. After evaluation of the options, the public had 60 days to provide feedback on Option B, a component of CARES which called for more resource sharing between North Chicago VA Medical Center and Naval Hospital Great Lakes. The VA's National CARES steering committee reviewed the comments and then made their recommendation to the Under Secretary of Health. Later the Secretary endorsed and announced the final decision in February 2002.

As previously mentioned, components of Option B calls for enhanced sharing opportunities with Naval Hospital Great Lakes and for the renovation of the North Chicago VA Medical Center into a Federal Ambulatory Care Center. Ultimately, the FACC will provide up to 598 beds that will include 27 acute care, 248 nursing home beds, 67 long-term psychiatric, and 186 domiciliary beds. The VA measures the progress of CARES by increased access, reduction in vacancies, and greater effectiveness in matching healthcare to the location and needs of veterans (CARES, CH 5 SDO).

Simultaneously, while Booz-Allen Hamilton consulted for the North Chicago VA Medical Center, SRA International Inc. analyzed the capacity of Naval Hospital Great Lakes to provide healthcare to their beneficiaries. While SRA's study suggested options to build a new ambulatory healthcare center for Great Lakes, it ultimately recognized the mutually beneficial relationship of sharing resources with North Chicago VA Medical

Center. Booz-Allen Hamilton's CARES report and SRA International Inc.'s study laid the groundwork for a strategic alliance between Naval Hospital Great Lakes and North Chicago VA Medical Center and led to the approval of the first Executive Decision Memorandums that facilitated large-scale integration of their resources.

History of DOD/VA Resource Sharing Agreements between North Chicago VA Medical Center and Naval Hospital Great Lakes

Today, the Next Generation Resource Sharing Agreement, also called the Inter-Service Support Agreement is being implemented. The Federal Ambulatory Care Clinic will eventually mark the full integration and consolidation of VA/DOD resources and facilities. See Figure 4 for a timeline of the development of DOD/VA joint ventures. Congress enacted the first VA/DOD sharing agreements in 1982 with the passing of the Sharing Act. Until now, resource sharing has been limited since it depended on excess capacity and very little of it is typically found in either federal healthcare system (MCHO-CL-MPR, 2002).

Timeline of Resource Sharing Agreements between North Chicago VA Medical Center
and Naval Hospital Great Lakes

1980	Laundry Service Agreement
1985	CATSCAN Agreement
1990	Professional Staffing Agreement
1995	Joint Replacement Agreement
2000	Inpatient Mental Health Clinic Agreement Executive Decision Memorandum
2005	Blood Donor Processing Center Agreement Operating Room/Emergency Room Agreement
2010	Federal Ambulatory Care Clinic

Figure 4. A history of resource sharing agreements from 1980 until 2010 shows increased integration in recent years.

Since the late 1970's, North Chicago VA Medical Center and Naval Hospital Great Lakes have shared resources to provide better access, and higher quality healthcare to their beneficiaries. Most sharing agreements last nearly five years and come to fruition as a result of grass roots proposals within medical departments at either hospital. After developing a proposal, the Sharing Council, chaired by the Commanding Officer of Naval Hospital Great Lakes and Director of Veterans Services at North Chicago VA Medical Center, is briefed. Any concerns are addressed and the proposal is sent to departments potentially affected by the new resource sharing agreement. The comptrollers then

provide an assessment of the financial feasibility of the project. Some departments delve into the detail of the proposal; still others rubber-stamp their approval. As a result, often when a policy gets implemented, problems arise due to the lack of specificity.

When a resource sharing agreement is in the approval process, key players need time for thorough review and their buy-in is necessary to achieve successful implementation of the policy (Leatt, Shortell, & Kimberly, 2000). In the past, all local resource sharing agreements were approved at the local level. Today, resource sharing agreements require approval at a federal level from the Bureau of Navy Medicine and the Department of Veterans Affairs; taking up to twelve months. Additionally, resource sharing agreements go through multiple layers of local approval and revisions from the Clinical and Administration workgroups and their subordinate subcommittees. More recently, when conducting a business case analysis of each proposal, North Chicago VA Medical Center and Naval Hospital Great Lakes consider cost of staff and equipment in relation to workload, a practice previously neglected in developing resource-sharing agreements.

In the early 1990's Naval Hospital Great Lakes entered into a sharing agreement with the North Chicago VA Medical Center for professional staff employed by the Department of Veterans Affairs to work at the naval hospital; primarily psychologists, psychiatrists, pharmacists, radiologists and nurses. In order to maintain continuity of care, Naval Hospital Great Lakes wanted to hire civilians. However, Naval Hospital Great Lakes contracting took too long to exercise and they could not compete with the wages offered by the North Chicago VA Medical Center. As a result, by 1992, North Chicago VA Medical Center agreed to hire 75 VA staff to work at Naval Hospital Great

Lakes. Later the Navy's Judge Advocate General stated that Naval Hospital Great Lakes was using North Chicago VA Medical Center as an employment agency and found the DOD/VA sharing agreement to be a negligent business practice (Manczko, personal communication, March 25, 2005).

This sharing agreement provided valuable lessons for future sharing agreements: First, employing VA physicians in a DoD facility requires adequate supervision and support staff for the VA practitioners. Second, both VA and DoD employees need to be equally compensated for the same job description. Problems arose when DoD employees were getting bonus incentives, while their VA counterparts did not (Manczko, personal communication, March 25, 2005).

The Laundry Sharing Agreement of the early 1980's provides another example of a learning opportunity for North Chicago VA Medical Center and Naval Hospital Great Lakes. Under this agreement, North Chicago VA Medical Center ran their own laundry facility and provided laundry services for Naval Hospital Great Lakes. Then in late 2001, North Chicago VA Medical Center began to outsource the laundry service to their Milwaukee facility to improve cost effectiveness. As a result of the outsourcing, Naval Hospital Great Lakes paid a higher cost and waited a longer turnaround period for their linens. North Chicago VA Medical Center's Milwaukee proposal was an unacceptable option because it required Naval Hospital Great Lakes to increase their inventory of linens and pay a higher fee for laundry services. Naval Hospital Great Lakes solicited new contract bids from Goodwill, but eventually hired a commercial entity.

Still, other sharing agreements were more successful and showed the benefits of economies of scale. During the late 1980's, Naval Hospital Great Lakes procured its first

CATSCAN in a sharing agreement with the North Chicago VA Medical Center. The VA gained access to use the CATSCAN and in return they provided two CATSCAN technicians. This agreement achieved an economy of scale for both federal organizations because they were able to treat a large volume of patients by pooling their resources together. While the demand for CATSCANS eventually led the North Chicago VA Medical Center to purchase their own, the initial demand made the CATSCAN sharing agreement financially attractive to both hospitals.

Historically, the credits and debts teetered between the two federal agencies. Before the general shift of healthcare services moved from inpatient to outpatient, Naval Hospital depended on North Chicago VA Medical Center for much of its inpatient care. Since North Chicago VA Medical Center provided more inpatient services, Naval Hospital Great Lakes became financially indebted to them. However, with the introduction of highly reimbursed total joint replacements, Naval Hospital Great Lakes quickly worked off its debt and the North Chicago VA Medical Center became indebted to Naval Hospital Great Lakes. Navy physicians gained higher patient volume for a high paying product line from this sharing agreement. For every three joint replacements on Veterans, Naval Hospital Great Lakes conducted one joint replacement on its own beneficiaries.

Throughout the history of VA/DoD resource sharing, the two federal agencies used one of two financial models: the Zero-Based Model, and the newer, Vendor Model. Theoretically, the Zero-Based Model asserts that the services used by either hospital will be equal and, therefore, result in no significant gains or losses for either agency. This model requires no money to be exchanged except as credits and debits on an EXCL

spreadsheet. The model became dysfunctional as running debt carried over from year to year and both facilities billed at different rates from what was agreed upon. Also, many medical departments complained that while they provided patient services, the parent organization delayed in compensating expended consumables used in Zero-Based Model patient care. Finally, the Government Accounting Office released a report in 2001 announcing the termination of all zero-based agreements.

Recently implemented and effective March 11, 2005 thru 2008, the Vendor Model follows the General Accepted Accounting Principles (GAAP) of modern accounting and, ideally, both federal agencies bill at the same agreed upon rates. Essentially, the two federal agencies are exchanging bills for services as if they were civilian corporations. Using this model makes it easier to track the demand for service lines with the Military Managed Healthcare System (M2) system and to bill other health insurers. Under the Vendor Model, the North Chicago VA Medical Center bills TRICARE instead of directly billing Naval Hospital Great Lakes. Additionally, the Vendor Model improves financial accountability and stewardship when real dollars are exchanged.

Future sharing agreements reflect the lessons learned from past sharing agreements; gradual adoption of policy is more effective than major policy change. For example, implementation of the new Vendor Model was implemented on a small scale by using it to purchase mental healthcare before the onslaught of a high volume of billing from the Operating Room and Emergency Room Sharing Agreement scheduled to commence in June 2006. The OR and ER resource sharing agreement includes four new operating rooms and sixteen new emergency examination rooms. Both agencies hope to

develop billing best practices before the execution of the sharing agreement brings 15,000 to 20,000 emergency cases, an additional 500 inpatient cases, and 1700 inpatient and outpatient surgeries annually.

Methods and Procedures

Purpose

To explore the proposition, known as the Iron Triangle Theory of Healthcare Integration, by (1) conducting a situational analysis of Naval Hospital Great Lakes and North Chicago VA Medical Center, (2) conducting informal interviews of executive staff and staff encountered during observational rotations through the two organizations and, (3) evaluating two resource sharing agreements that propose the consolidation of services between the Federal organizations.

Population and Variables

This study considers integration between two distinct organizations in the Department of Defense, Naval Hospital Great Lakes, and in the Department of Veterans Affairs, North Chicago VA Medical Center. In order to understand the organizational behavior associated with integration and, specifically, with resource sharing agreements, the population encompasses the collective healthcare system of these organizations rather than just specific individuals. This level of granularity, viewing the organization as the unit of analysis, affords the researcher a population that incorporates the effects of corporate culture, idea champions, and group dynamics (Lafrance, personal communication, September 30, 2003).

Defined in the introduction, the independent variables are cost, quality, and access. The dependent variable is the occurrence of integration between organizations.

Both the independent and dependent variables are objectively defined and qualitatively measured.

Methods of Data Collection

In order to objectively define the variables of this qualitative analysis this thesis employs three methods of data collection within the two distinct populations. The researcher will conduct a situational analysis of the Federal organizations, carry out informal interviews of staff from Naval Hospital Great Lakes and North Chicago VA Medical Center, and perform a document review of two resource sharing agreements. The multiple methods of data collection improve the reliability of conclusions made about the relationship of cost, quality, and access with respect to the success of integration.

Situational Analysis of Naval Hospital Great Lakes and North Chicago VA Medical Center

The situational analysis notes the internal and external environments, mission/vision/values and reviews the Strengths, Weaknesses, Opportunities, and Threats (SWOT) of each organization. The data for the situational analysis was obtained through interviews of staff from both organizations and a stakeholder map. The SWOT provides a summary of the overall environment in which the two Federal organizations operate (Pesnell, 2004). Since the primary customers of these organizations must receive healthcare from either of the institutions, the researcher determined that a Service Area Competitor Analysis and a Porter's Analysis are unnecessary. All analytical tools are used in accordance with definitions and examples illustrated by Ginter, Swain, and Duncan (1998).

Interviews of Staff from Naval Hospital Great Lakes and North Chicago VA Medical Center

To gain a retrospective view on integration between the two facilities, the researcher interviewed executive staff from North Chicago VA Medical Center and Naval Hospital Great Lakes. The criteria for their selection included: active leading role in current DOD/VA sharing agreement negotiations, a corporate memory of integration negotiations and a fundamental understanding of history between Naval Hospital Great Lakes and North Chicago VA Medical Center. Using a modified Delphi technique, the researcher conducted informal interviews with executive staff, consolidated their views and categorized them into general themes in the Situational Analysis and Assessing the Outcome of Resource Sharing Agreements: The Iron Triangle Theory of Healthcare Integration. The researcher carried out a second formal personal interview with a structured questionnaire (Ginter, Swayne, & Duncan, p. 77-78, 1998) (See Annex 1). The questionnaire consisted of succinct multiple-choice questions and a few short answer questions. In order to maintain the objectivity of the questionnaire, the researcher did not discuss the contents with the executive staff member. In addition to these interviews, the researcher shadowed staff in both facilities over the course of six months and conducted ongoing interviews.

Document Review of Resource Sharing Agreements between Naval Hospital Great Lakes and North Chicago VA Medical Center

The researcher will conduct a document review of the Inpatient Mental Health Clinic and the Blood Bank/Donor Processing Center resource sharing agreements. After reviewing each statement within all sections of the agreements, the statements are

organized into categories depending on their relationship to cost, quality, or access.

Within the context of the results of the situational analysis and informal interviews, the document review points out the barriers to the successful implementation of the resource sharing agreements. Specifically, the document review considers whether the resource sharing agreement addresses mission/vision, financial accountability, environment, organization strengths and weaknesses, organizational ethics, culture, communication, governance, leadership, specific goals, human resources, and political process of the involved organizations.

Situational Analysis of North Chicago VA Medical Center and Naval Hospital
Great Lakes

A situational analysis of both organizations provides a foundation from which to understand the motivation for North Chicago VA Medical Center and Naval Hospital Great Lakes to form a strategic alliance. This situational analysis references several strategic analyses of the Department of Defense and the Department of Veterans Affairs that were previously conducted at the national and local levels. In 1991, the *Report of the Commission on the Future Structure of Veterans Health Care* made the first recommendations to improve cost, quality, and access by merging DoD and VA resources (Presidential Task Force, 2003). Seven years later, Congressional advisory groups echoed this sentiment in the *Healthcare Advisory Group Report to the Congressional Commission on Service Members and Veterans Transition Assistance* (President Task Force, 2003). The political pressure escalated when the Government Accounting Office reports, issued in 2000 and 2001, advised Congress to give specific guidance for VA/ DoD collaboration. Locally, as mentioned in the Tale of Two Hospitals, Booz-Allen Hamilton and SRA, Inc conducted a strategic analysis of North Chicago VA Medical Center and Naval Hospital Great Lakes, respectively. Both studies independently came to the same conclusions as the national studies. Despite these multiple reports, the VA/DoD appear to ignore their recommendations and the resource sharing agreements “have been at best marginal, or at worst, superficial” (Presidential Task Force, 2003, p. 4).

A situational analysis, the major building block of a strategic analysis, collects facts about an organization and its surroundings. Ginter, Swayne, and Duncan explain

that a situational analysis drives an organization's strategy and captures the interaction of the organization's mission/vision/values/goals, external environment, and internal environment. A situational analysis of North Chicago VA Medical Center and Naval Hospital Great Lakes encompasses all of these areas.

Mission, Vision, and Values of North Chicago VA Medical Center

An organization's mission largely dictates the major tasks to be carried out (Shortell & Kaluzny, 2000). Updated at the beginning of 2005, the mission of the North Chicago VA Medical Center declares, "We are a caring community, proud to provide patient centered, coordinated healthcare to Veterans, Navy, and other VA/DoD sharing patients" (North Chicago VA, 2005). Externally, this mission tells VA/DoD beneficiaries that their healthcare drives operations at North Chicago VA Medical Center. Internally, this mission motivates and directs the healthcare staff.

For the future, North Chicago VA Medical Center envisions: "Creating the future of federal healthcare through excellence in patient care, customer service, education and research" (North Chicago VA, 2005). The common beliefs that guide the North Chicago VA Medical Center are summarized by the following values: trust, diversity, teamwork, pride, and creativity. These values emanate in their "Proud to Care" marketing campaign.

The CARES mission and vision also influences the North Chicago VA Medical Center. The CARES mission reads: "CARES is a focused, data-driven planning process that evaluates future demand for veterans' healthcare services against current supply and realigns VHA capital assets in a way that results in more accessible, high quality

healthcare for more veterans.” The CARES vision aims to improve cost, quality, and access:

CARES will improve access to and the quality and cost-effectiveness of veterans’ healthcare by realigning capital assets and healthcare services based upon the creation of a sustainable, flexible planning and implementation process that integrates clinical demand and facilities’ management (Department of Veterans Affairs, 2005).

Mission, Vision, and Values of Naval Hospital Great Lakes

The mission of Naval Hospital Great Lakes carries an operational tone, but also focuses on the patient, “We are committed to: Operational readiness through training and Force Health Protection; excellence in recruit and student health; and comprehensive healthcare for all who are entrusted to our care” (Naval Hospital Great Lakes, 2005). The vision addresses patient care and alludes to integration with North Chicago VA Medical Center:

Naval Healthcare Great Lakes creates an environment of excellence to build a mission-ready, healthy, educated force. Through the most progressive federal partnership, we are leaders and stewards who ensure comprehensive wellness, prevention and healthcare services to all entrusted to our care (Department of Veterans Affairs, 2005).

Naval Hospital Great Lakes’ values reflect those of the entire Navy: honor, courage, and commitment. Honor is demonstrated by: integrity, loyalty, respect, ethical decisions, and responsibility. Courage is shown through innovation, empowerment, and equity. Commitment is cemented by clear communication, patient centered care, quality, and efficiency (Naval Hospital Great Lakes, 2005). Naval Hospital Great Lakes sets five

main goals that encompass business planning, staff resources, readiness, integrating technology, and patient-focused, customer-centered care. These goals provide Naval Hospital Great Lakes benchmarks to measure the success of resource sharing agreements.

While compatible, North Chicago VA Medical Center and Naval Hospital Great Lakes follow “different missions that at times create inconsistencies and roadblocks to a uniform approach to healthcare delivery” (Presidential Task Force, 2003, p. 23). Due to their different organization missions, it is important that North Chicago VA Medical Center and Naval Hospital Great Lakes agree upon a common mission and pursue the same vision in their resource sharing agreements.

External Environmental Analysis of North Chicago VA Medical Center

The external environment typically refers to the technological, political, economic, social, and regulatory forces that exert influence on the organization (Ginter, Swayne, and Duncan, 1998). Political, economic, and regulatory forces historically exerted the greatest influence on North Chicago VA Medical Center and Naval Hospital Great Lakes.

The Department of Veteran Affairs healthcare system is comprised of 21 VISNs. VISN 12 comprises three regions: the northern, central and southern markets of Chicago, Illinois. As one of seven medical centers in VISN 12, North Chicago VA Medical Center serves a suburban population on its 226-acre campus in the southern market. In addition, North Chicago VA Medical Center manages three community-based outpatient clinics in Evanston, Gurnee, and McHenry that serve veterans in remote geographic areas. The North Chicago VA Medical Center is centrally located between the major populations of Chicago, Illinois and Milwaukee, Wisconsin. Therefore, as the population ages the ideal

location of North Chicago VA Medical Center will play a critical role in providing nursing home care to its Northern Illinois and Southern Wisconsin beneficiaries (Department of Veterans Affairs, 2005).

With an aging demographic, North Chicago VA Medical Center modified their focus from a purely medical model to one that prioritizes the prevention of illness. As a result, the medical services shifted from an inpatient, hospital-based system to an outpatient, integrated health system that addresses the promotion of healthy lifestyles and the prevention of disease. North Chicago VA Medical Center provides the following services: primary and preventive care, surgery, women's health, mental health and substance abuse treatment, home healthcare, respite care and a pharmacy (Department of Veterans Affairs, 2005).

The southern market of VISN 12 serves roughly 108,660 enrollees (Department of Veterans Affairs, 2005). Designate by priority level, veterans receive care based on their degree of disability and ability to pay. Of the total Veteran population in the southern market, 73,629 of the Veterans receive care within the VA healthcare system since they fall into priority 1-7, while the rest of the Veterans, whom are priority 8, must utilize other health insurance.

SWOT (Strengths, Weaknesses, Opportunities, and Threats) Analysis for North Chicago VA Medical Center

Strengths

North Chicago VA Medical Center, unlike most healthcare systems enjoys a captured patient population. Regardless of the access to and quality of healthcare they provided to their patients, North Chicago VA Medical Center is the sole provider of

healthcare to low-income Veterans. They possess a monopoly on Veteran healthcare and have little risk of other competitors in their market.

An evident strength for North Chicago VA Medical Center is its proximity to Naval Hospital Great Lakes and other medical institutions. Given its location, North Chicago VA Medical Center plays a paramount supporting role to Naval Hospital Great Lakes in providing aid during local and national disasters. In addition, the propinquity of the medical systems facilitates the cooperation necessary to implement resource sharing agreements. Finally, North Chicago VA Medical Center provides Naval Hospital Great Lakes staff access to training at their facilities. The North Chicago VA Medical Center also provides a learning opportunity for students at Chicago Medical School and Finch University of Health Science.

Attention from the President and Congress to improve veteran's healthcare and to promote DoD/VA collaboration benefits North Chicago VA Medical Center. For example, veteran's access to care increased with the passing of the Veteran's Health Care Eligibility Reform Act of 1996 (Public Law 104-262). This law expanded the VA's mission from treating veterans with service-connected injuries and indigent veterans to providing comprehensive care to all enrolled veterans. Then, in 1999, access to home and long-term care improved with enactment of the Veteran's Millennium Health Care and Benefits Act (Public Law 106-117). This led to the establishment of satellite community based outpatient clinics. While legislation removed many healthcare barriers for veterans, funding in recent budgets fails to keep pace with the new demand; thus, creating a new access barrier. Still, North Chicago VA Medical Center enjoys the privilege of strong representation on Capitol Hill. A political ally to another former

Illinois Congressman, Secretary of Defense John Rumsfeld, Congressman Mark Kirk successfully pleads for the healthcare needs of veterans in his congressional district.

Weaknesses

Increased political scrutiny reveals the weaknesses of North Chicago VA Medical Center and Naval Hospital Great Lakes. Receiving attention from the Executive Branch, President Bush identified “improved cooperation between the Department of Defense and Department of Veterans Affairs in providing care to those that served” in the top ten challenges for his Administration (Presidential Task Force, 2003, p. 4). In 2003, the Presidential Task Force cited the effects of inadequate funding within the VA healthcare system, stating that more than 236,000 veterans wait more than six months for initial or follow up visits (2003, p.1). At North Chicago VA Medical Center, the average veteran waits 28 days for an initial appointment.

Historically, North Chicago VA Medical Center struggles with fiscal planning and accountability within their organization. The comptroller of North Chicago VA Medical Center reports to the regional VISN 12 rather than to the local Director of the VA facility. This puts the Director of North Chicago VA Medical Center at a disadvantage in maintaining fiscal accountability since there is a missing link in the administrative chain of command between the Director and the comptroller.

The public perception of patient care lags behind other medical facilities in the geographic area. Nested near the affluent suburbs of Libertyville and Lake Forest, the North Chicago VA Medical Center’s aged facilities and limited funding pale in comparison to those of their neighbors. Additionally, North Chicago VA Medical Center possesses a negative public image that dates back to the Vietnam era when questionable

treatment of mental health patients was publicized in local newspapers. Despite North Chicago VA Medical Center's efforts to shed this stigma, Naval Hospital Great Lakes voices a concern that the perception of the quality care received at the VA falls short of Navy standards (HM2 Hawkins, personal communication, May 10, 2005).

North Chicago VA Medical Center and Naval Hospital Great Lakes are limited by their resource capacity (Presidential Task Force, 2003). This limited capacity creates access barriers for VA/DoD beneficiary referrals since they receive care based on space availability and eligibility (Manzcko, April 6, 2005). Access presents a problem to VA health systems across the country. The Presidential Task Force cites, "The persistent disparity between demand and funding in VA significantly inhibits effective collaboration arrangements [resource sharing agreements] and the delivery of health care itself" (2003, p. 8). While Congress theoretically gives veterans access to care, realistically their access is limited by inadequate funding; the effects of appropriated monies falling short of fulfilling legislated promises. Hence, improving access is an important expected outcome for North Chicago VA Medical Center when they negotiate resource sharing agreements freeing up funding with downstream positive effects of improving access.

Opportunities

Cooperation between North Chicago VA Medical Center and Naval Hospital Great Lakes improves the transition process of military service to veteran status (Presidential Task Force, 2003). With the current isolation of DoD and VA healthcare systems, many veterans find "gaining entry into the [VA] system frustrating and time consuming" (Presidential Task Force, 2003, p.6). Increased standardization of

information systems at North Chicago VA Medical Center and Naval Hospital Great Lakes would not only facilitate the seamless transition of a veteran out of military service but also would improve veteran's access to care.

Threats

Some politicians on Capitol Hill feel that local VA and DoD hospitals fail to effectively work together and, thereby, compromise the quality of care provided to the patient. The Congressional Transmission Commission summarizes that although, "Senior leadership in both Departments support the principle of sharing [resource sharing agreements], day to day decisions are the product of separate staffs working independently, without taking into account the need or resources of the other Department," consequently, both systems are "so ineffective they break faith with those who served, and currently serve, their Nation in uniform" (1998). After 20 years of encouraging the DoD and VA to implement successful integrations, statements like this from Congressional committees indicates their patience is waning and that a complete overhaul of the current VA/DoD healthcare systems may have more appeal than dealing with the frustration of the current organizations' inability to cooperate.

External Environmental Analysis of Naval Hospital Great Lakes

Naval Hospital Great Lakes and its three clinics operate 38 beds. Once a primary care hospital, it has been downsized to primarily an outpatient clinic. Within a forty-mile radius, Naval Hospital Great Lakes' service area provides healthcare to roughly 500,000 beneficiaries; which includes 20,000 recruits annually (Military Managed Healthcare System, 2005). The patient mix is comprised of the worried well; active duty, military retirees, veterans and dependents. The leading product lines at Naval Hospital Great

Lakes are primary care, surgical services, emergency department, outpatient mental health, internal medicine, and several ancillary services. Generally, North Chicago VA Medical Center provides mostly inpatient services, while Naval Hospital Great Lakes focuses on ambulatory care.

SWOT (Strength, Weaknesses, Opportunities, and Threats) for Naval Hospital Great Lakes

Strengths

Like North Chicago VA Medical Center, Naval Hospital Great Lakes also benefits from a captured patient population—Navy recruits. Politically, Naval Hospital Great Lakes plays an integral role in providing medical care for all Navy recruits, since Great Lakes Naval Base is the only remaining training base.

In comparison to North Chicago VA Medical Center, the product lines provided by Naval Hospital Great Lakes treat a higher patient volume and receive higher reimbursement. Most Veterans with high acuity illness are sent to Naval Hospital Great Lakes because North Chicago VA Medical Center lacks the medical specialties and/or the cost of care is less than in the network. For example, as mentioned in the History of Resource Sharing Agreements, joint replacements became a cash cow for Naval Hospital Great Lakes and helped them develop a niche market.

Weaknesses

With outdated, failing facilities, Naval Hospital Great Lakes encountered difficulty in getting their physical plant to pass the last two inspections from Joint Commission on Accreditation of Healthcare Organization (JCAHO), a regulatory agency. Constructed almost 50 years ago, under the auspices of a large inpatient population, Naval Hospital Great Lakes slowly adapts its physical infrastructure to the requirements

of new technology and less invasive ambulatory care services. A highly regulated business process hampers Naval Hospital Great Lakes facilities lifecycle management, whereas North Chicago VA Medical Center lacks a strategic facility focus (Presidential Task Force, 2003, p. 57). The Presidential Task Force criticizes the vulnerabilities of facilities maintenance within both organizations: "VA and DoD must invest adequately in the necessary infrastructures, and create abilities to respond to a rapidly changing environment" (2003, p.57). Effective and efficient facilities maintenance is key to future VA and DoD collaboration.

The inability for North Chicago VA Medical Center and Naval Hospital Great Lakes to share patient information electronically presents a weakness for future integration. In October 2002, the VA stated in an Information Paper that "The success of any project to increase the sharing of healthcare resources between the VA and the DOD is greatly dependent on the ability to transfer, or to obtain healthcare information" (MCHO-CL-MPR, 2002). To facilitate the development of a universal information technology system Congress stated that pharmacy services, billing, records and electronic records systems must be compatible.

Extensive benefits of electronic medical records would include: improved coordination of emergency support of DoD healthcare systems in times of war or national emergency, smoother transition of active duty into veteran status, and a consolidated database for epidemiological studies. In addition, "The development and use of bi-directional EMR [electronic medical records] would facilitate collaboration in the delivery of health care services, enhance effectiveness of care, and reduce medical errors and attendant costs" (Presidential Task Force, 2003, p.26). However, regulations, like

Health Insurance Portability and Accountability Act (HIPAA), place patient privacy limitations on the full integration of information technology systems between North Chicago VA Medical Center and Naval Hospital Great Lakes.

Opportunities

Today, VA/DoD Incentive Programs, a voluntary opportunity to develop new product lines, present an opportunity for funding of future strategic alliances between Naval Hospital Great Lakes and North Chicago VA Medical Center. Approval of their joint proposals by the Healthcare Executive Council, a committee composed of DoD and VA staff, grants Naval Hospital Great Lakes and North Chicago VA Medical Center seed money to start new programs that may eventually become self-sustaining. Recently, the two agencies received approval and funding for a Women's Health program for VA and DoD beneficiaries. Future incentive programs the two agencies have applied for are a joint Magnetic Resonance Imager, fiber optics for integration of information technology between the two federal organizations, and a cooperative Oncology program.

Another opportunity for surgeons at Naval Hospital Great Lakes is to increase their patient volume by seeing more VA beneficiaries. Treating Veterans at Naval Hospital Great Lakes not only perpetuates military pride, but it also gives the Navy practitioner a wider and more challenging scope of practice, or the like on senescent patients, an underrepresented population in Naval Hospital Great Lakes normal patient mix.

Threats

With the realization of defense spending cutbacks Base Realignment and Closures (BRACs) terrorize the future of many unsuspecting military bases. Recently, the

Pentagon recommended closing the hospital corpsman training school at Naval Hospital Great Lakes that results in the relocation of almost 2,000 Navy personnel. In addition, the transformation of military healthcare provider jobs into civilian positions threatens the vitality of Naval Hospital Great Lakes. Resource sharing agreements can not only augment the medical staff lost in recent BRACs, but also prevent future downsizing of Naval Hospital Great Lakes by establishing North Chicago VA Medical Center's dependence on a strategic alliance with the Navy.

Internal Environmental Analysis of North Chicago VA Medical Center and Naval Hospital Great Lakes

Recognizing cultural differences, and, more importantly, bridging these differences depends on identifying the source from which the dissimilarities originated. Looking at the internal environment of North Chicago VA Medical Center and Naval Hospital Great Lakes suggests that their dissimilarities arise from Congressional legislature, human resource operations, patient loyalties, organizational structure, length of staff employment, and professional acumen of staff.

Recent legislative attempts to increase collaboration between the Federal organizations work to overcome past legislation that created historical differences in the DoD and VA healthcare systems. "The lesson for all merging healthcare organizations is that cultural issues, whether or not religious differences are involved, should be reviewed carefully, before moving forward" (Eberhart, 2001). For example, many differences in fiscal stewardship between the North Chicago VA Medical Center and Naval Hospital Great Lakes began with Congressional legislature, title 38 and title 10, U.S. Code. Under title 38, U.S. Code, healthcare is a benefit; not an entitlement to United States' Veterans. Title 10, U.S. Code states healthcare is an entitlement to military active duty and their

beneficiaries: "Under joint regulations to be prescribed by the administering Secretaries, a member of a uniformed service who is on active duty is entitled to medical and dental care in any facility of any uniformed service" (Cornell, May 10, 2005).

Due to the distinction between a benefit and an entitlement, healthcare delivery is viewed very differently by the two federal organizations. For the VA, they provide healthcare as long as the funding is available, whereas the Navy must budget their funding so that they can provide healthcare to all beneficiaries. As a result, Naval Hospital Great Lakes is traditionally more fiscally savvy, and plans carefully; while North Chicago VA Medical Center reacts to the immediacy of their situation, and spends (Ulnick, personal communication, April 4, 2005).

A contrast in human resource operations and patient loyalties creates a noticeable distinction in the motivation and corporate citizenship of staff at North Chicago VA Medical Center and Naval Hospital Great Lakes. While both healthcare systems are federal institutions, Naval Hospital Great Lakes primarily employs military service members; whereas, North Chicago VA Medical Center employs civil servants. As healthcare providers of military duty members and retirees, military staff appear to have an air of superiority to civilian staff because they feel they have a better appreciation of the patient (Manczko, personal communication, April 6, 2005). As a collective organization, North Chicago VA Medical Center's loyalty is to Veterans, and, as a result, it shares a symbiotic relationship with Congressman Mark Kirk. As mentioned earlier, the local Congressman protects North Chicago VA Medical Center from funding cutbacks and in return the VA hospital provides necessary healthcare to voting Veterans.

Organizational structure variation exists between the two Federal organizations. Characterized by a traditionally top-down military chain of command, leadership and decision making is vertically centralized at Naval Hospital Great Lakes, whereas North Chicago VA Medical Center utilizes a horizontally decentralized team approach (Leatt, Shortell, & Kimberly, 2000). At Naval Hospital Great Lakes more decisions originate from top management rather than from individuals. For the North Chicago VA Medical Center, decisions emerge from various departments and are then coordinated at the organizational level. These polarized leadership styles create a turbulent environment for the implementation of resource sharing agreements.

The length of time for which staff at the two federal institutions is employed also affects the organizational culture. At Naval Hospital Great Lakes, on average a staff member works at the facility for three years. Whereas at North Chicago VA Medical Center staff typically stay within the same facility for 10 years (Manczko, April 4, 2005).

Additionally, North Chicago VA Medical Center employees are often "homegrown." VA staff members may start their careers as technicians and rise through the ranks; this is exemplified by their current Director who began working for the VA nearly twenty years ago as a health technician. In contrast, DoD employees are required to attain specific qualifications and degrees before they can be promoted to senior staff positions. This difference in lengths of employment and professional acumen creates profound differences in the motivation (academic preparation, exposure to varied healthcare environments, leadership skill set, etc.) and corporate citizenship within each organization.

Discussion

Through this situational analysis of North Chicago VA Medical Center and Naval Hospital Great Lakes, the researcher establishes a critical appreciation of their motivation to form a strategic alliance, such as a resource sharing agreement. Zajac, D'Aunno, and Burns state, "Understanding the strategic intent of an alliance can be a critical success factor for the alliance" (2000, p. 316). This situational analysis provides a snapshot of each organization and a view of their compatibilities for forming a strategic alliance.

The Presidential Task Force points out that a thorough situational analysis would have prevented many of the barriers to past integrations between the DoD/VA,

By most accounts, organizational and cultural barriers have consistently thwarted implementation. The operational levels within VA and DoD have not been routinely accountable to a clear set of directives, goals, measures, or strategic plans with regard to collaboration. Furthermore, there have been no processes implemented to foster communication in collaboration at the local and regional levels (2003, p.15).

Mission, vision, and values provide direction to an organization. An awareness of the external environment provides an organization an appreciation of technological, political, economic, social, and regulatory forces that impact its overall strategy. Thoughtful consideration of an organization's internal environment leads to the successful implementation of strategy, like a resource sharing agreement.

The situational analysis of the two federal organizations demonstrates that the North Chicago VA Medical Center and Naval Hospital Great Lakes seek different expected outcomes. Generally, North Chicago VA Medical Center values improvements to access and quality. The Presidential Task Force enforces these expected outcomes,

“The Presidential Task Force envisions a VA health care system that is no longer impaired by the mismatch between resources and demand, working collaboratively with the DoD health care system to increase the accessibility and quality for enrolled veterans, including military retirees” (2003, p. 6). While Naval Hospital Great Lakes appreciates improvements to access and quality, they primarily focus on cost. The expected outcomes of the federal organizations shift depending on the product line of the resource sharing agreement.

Document Review: An Assessment of Two Resource Sharing Agreements
between North Chicago VA Medical Center and Naval Hospital Great Lakes

Resource sharing agreements lead to gradual changes in organizational design. According to Leatt, Shortell, and Kimberly (2000), organizational design “refers to the way in which the building blocks of organization—authority, responsibility, accountability, information, and rewards—are arranged or rearranged to improve effectiveness and adaptive capacity. Organization design and redesign are dynamic, being simultaneously both outcome and process” (p. 275). This statement establishes that optimal resource sharing agreements are a dynamic, constantly adapting process and improve the effectiveness of healthcare delivery, perhaps measured by cost, quality, and access. Unfortunately, there are many significant obstacles to impede integration given the differences in personnel management, training programs, facilities, infrastructure, information technology and management, statutes and business practices between North Chicago VA Medical Center and Naval Hospital Great Lakes (Presidential Task Force, 2003).

This document review specifically looks at resource sharing agreements that propose integration which result in changes to the organization design for two departments: inpatient mental health and Blood Bank/Blood Donor Processing Center. The purpose of the document review is to point out the barriers to the successful implementation of the resource sharing agreement. In a later section, this thesis posits that the Iron Triangle Theory of Healthcare Integration provides a framework to evaluate

the outcomes of the resource sharing agreements, and determine future implementation strategies drawn from the situational analysis and document reviews.

Within the context of the situational analysis of North Chicago VA Medical Center and Naval Hospital Great Lakes, the research reviews the verbiage of the resource sharing agreement documents. "Ideas about the type of design that might be appropriate should be derived from the organization's mission and strategic planning process" (Pearce, 1982, p.). Much like conducting a strategic analysis, the document review considers whether the resource sharing agreement addresses mission/vision, financial accountability, organizational ethics, culture, communication, governance, leadership, and specific goals of the involved organizations. Throughout the document review, the success of either resource sharing agreement depends on whether these factors are adequately addressed.

Document Review of Resource Sharing Agreement for an Inpatient Mental Health Clinic

In October 2002, the DoD/VA Task Force recommended increased partnering between Naval Hospital Great Lakes and North Chicago VA Medical Center. This proposal formally approved by Robert H. Roswell, the Veterans Administration Secretary for Health, and William Winkenwerder, Jr., the Assistant Secretary of Health Affairs, laid the groundwork for phase I of integration between Naval Hospital Great Lakes and North Chicago VA Medical Center. This phase included implementation of the Inpatient Mental Health Clinic resource sharing agreement and the Blood Bank/Blood Donor Center resource sharing agreement. The Inpatient Mental Health Clinic resource sharing agreement proposed that North Chicago VA Medical Center treat Navy mental health patients at their Acute Mental Health Inpatient Unit and provide lodging for discharged

mental health patients at their Psychiatric Medical Holding Unit. In exchange, Naval Hospital Great Lakes pays monetary compensation for the services and provides psychiatric support staff. Naval Hospital Great Lakes viewed the Inpatient Mental Health Clinic as an opportunity to cut costs, whereas North Chicago VA Medical Center saw it as an opportunity to raise revenue—these opposite views fueled their many disagreements throughout the implementation of the resource sharing agreement.

Mission/Vision.

While the Inpatient Mental Health Clinic resource sharing agreement outlines a stated purpose, it lacks a common vision to drive the success of its implementation. The stated purpose of the resource sharing agreement is: “to establish guidelines, a vendor relationship for reimbursement methodology, and parameters for the provision of inpatient Mental Health Services for appropriate DoD beneficiaries at the North Chicago Veterans Affairs Medical Center” (Resource Sharing Agreement, 2004). Similar to the development of other resource sharing agreements Commander Ulnick comments, “The analysis of workload, staffing and space utilization was not done before the political decision was made to initiate the agreement” (personal communication, April 4, 2005). As a result, this resource sharing agreement provides a short-term fix to satisfy political agendas, but it lacks long-term vision that ensures accountability and a viable relationship between North Chicago VA Medical Center and Naval Hospital Great Lakes.

Financial Accountability.

A lack of due diligence in fiscal planning by North Chicago VA Medical Center explains the negative outcome of the Inpatient Mental Health Clinic resource sharing agreement. From the beginning, North Chicago VA Medical Center intended to make a

profit from the product line, even though mental health services typically lose money for healthcare systems. As soon as the resource sharing agreement began, North Chicago VA Medical Center lost money because they failed to accurately predict patient volume and reimbursements (Ulnick, personal communication, April 4, 2005). North Chicago VA Medical Center receives reimbursement of CHAMPUS maximum allowable charge (CMAC) – 10% for a specific Diagnosis Related Group (DRG) from Naval Hospital Great Lakes via Palmetto Beneficiary Government Accounting (PGBA), a TRICARE contractor fiscal intermediary. The CHAMPUS maximum allowable charge, for inpatient or outpatient setting, is the maximum amount TRICARE will cover for nationally established fees (Humana Military Healthcare Services, 2005). This fee does not include ancillary costs or professional fees. North Chicago VA Medical Center accumulated a debt rather than a profit because of low patient volume, underestimated reimbursements, and overstaffing for the acuity of Navy beneficiaries. To compensate their losses, North Chicago VA Medical Center requested a per diem for Navy patients hospitalized each day beyond the prescribed DRG capitation. However, the Naval Hospital Great Lakes denied the request, stating that an increase in the per diem would provide North Chicago VA Medical Center no incentive to discharge the patient.

Another area of reimbursement negotiation involved the daily rate for medical hold patients. Some mental health patients are discharged from the Acute Mental Health Inpatient Unit and placed in medical hold status because they are either processing out of the military or unable to return to their recruit company at Great Lakes Training Command. North Chicago VA Medical Center suggests that the negotiated rate of \$34/day should increase to \$118/day in order to meet the staffing needs for the

Psychiatric Medical Holding Unit within their Acute Mental Health Inpatient Unit. Navy Hospital Great Lakes suggested that physically separating the Psychiatric Medical Holding Unit from the Acute Mental Health Inpatient Unit would alleviate the need to employ more staff (Ulnick, May 2, 2005).

Culture and Organizational Ethics.

Additionally, differences in organizational ethics contribute to the negative outcomes of the Inpatient Mental Health Clinic resource sharing Agreement. A frequent byline from the Director of North Chicago VA Medical Center is that his "organization expects the Navy to show good faith in reimbursing for mental health services." The Navy responds that they are following the letter of the contract and North Chicago VA Medical Center may submit a revision to the contract if they are unsatisfied with the status quo. This debate causes angst between the two organizations (Ulnick, personal communication, April 4, 2005). The Navy feels they have acted ethically in implementing the resource sharing agreement. Especially, since they offered to bear the financial risk during initial negotiations of the Inpatient Mental Health Clinic resource sharing agreement. Specifically, Naval Hospital Great Lakes originally proposed leasing the mental health ward from North Chicago VA Medical Center, providing their own staff, and paying their own utilities. However, North Chicago VA Medical Center chose to take the risk with eager anticipation of making a profit from the mental health product line. As a result mental health resource sharing agreement negotiations, the working relationship between the organizations began to decay (Ulnick, personal communication, April 4, 2005).

Communication.

A lack of open communication degraded the trust and confidence between Naval Hospital Great Lakes and North Chicago VA Medical Center. Following the undesired outcome regarding low reimbursement for per diem beyond the DRG capitation and the daily charge for patients in Psychiatric Medical Holding Unit, North Chicago VA Medical Center sought guidance from higher authority. They entered into negotiation with TRICARE Region Office North, and excluded Naval Hospital Great Lakes in determining new rates for mental health services provided to Navy beneficiaries. The original contract for mental health patient referrals between Naval Hospital Great Lakes to North Chicago VA Medical Center works as a closed network. By negotiating new rates with TRICARE Region Office North, North Chicago VA Medical Center essentially agreed to open the network. Under this new agreement North Chicago VA Medical Center would receive \$118/day for patients in medical hold, but Naval Hospital Great Lakes could send their patients to any healthcare system in the network since North Chicago VA Medical Center no longer had the right of first refusal. Uninvited to participate in these negotiations, Naval Hospital Great Lakes sought legal council to determine which of the contracts would have legal precedent. Consequently, Naval Hospital Great Lakes felt betrayed and developed a greater apathy and distrust of North Chicago VA Medical Center (Ulnick, personal communication, April 4, 2005).

Governance and Leadership.

Even though the resource sharing agreement addresses dispute resolution, it fails to give a governing body clout to mediate potential disagreements between Naval Hospital Great Lakes and North Chicago VA Medical Center. The Inpatient Mental Health Clinic resource sharing agreement punctuates that all disagreements should find

resolution at the local level through an informal discussion with a mediator, followed by a formal submission of a complaint to the other party, and, finally, an official meeting to resolve the dispute. Additionally, the resource sharing agreement falls short of addressing the manner in which the offending party will demonstrate accountability or providing an alternative if the disagreement remains unresolved.

Specific Goals.

Access and quality are compromised by a lack of specific standards to ensure accountability for the healthcare of DoD and VA patients. As stated in the literature review, resource agreements must contain clear goals, because "real accomplishment comes from specifics. Goals define the routine, the day-to-day business. Goals are the statements of continuing intended results that are both necessary and sufficient to your concept of success" (Shortell & Kaluzny, 2000, p. 34). Lacking specific goals, the resource sharing agreement for Inpatient Mental Health Clinic leaves too much room for interpretation by staff at Naval Hospital Great Lakes and North Chicago VA Medical Center. General intentions like, "Under this agreement will result in no reduction in the range of services, quality of care or established priorities of care provided to the DoD beneficiary population" are not clarified with specifics that cite the "range of services," define the "quality of care," or rank the "priorities of care" (Interservice Support Agreement, 2004). Not only does the resource sharing agreement fail to address the specific care DoD patients receive but it also ignores the potential impact this integration may have on the access and quality of mental healthcare Veterans receive.

Discussion

The implementation of the Inpatient Mental Health Clinic resource sharing agreement resulted in a negative integration, because both organizations focused on the same expected outcome, cost, while giving less consideration to the other outcomes, access and quality. In planning the integration of mental health facilities, North Chicago VA Medical Center and Naval Hospital Great Lakes placed too much emphasis on the bottom line (Bradford & Duncan, 2000; Hoffman, 1996). Second, the resource sharing agreement lacked a common vision and specific goals to drive the implementation of the resource sharing agreement while accounting for patient access and the quality of mental healthcare delivered by the Psychiatric Medical Holding Unit and an Acute Mental Health Inpatient Unit (Lumsdon, 1996; Hansen, 1996; Bradford & Duncan, 2000). Third, a lack of communication and the poor development of trust prevented the two federal organizations from getting past historical stigmas and facilitating the melding of cultures (Taylor, 2005; Bradford & Duncan, 2000; Harrigan, 1985). Hence, the expected outcomes were not achieved by the resource sharing agreement and an imbalance of cost, quality, and access resulted from the integration.

Document Review of Resource Sharing Agreement for a Blood Bank/ Blood Donor Processing Center

An example of a trading alliance, the Blood Donor Processing Center allows North Chicago VA Medical Center and Naval Hospital Great Lakes to combine resources in order to create a product line they both need for their healthcare systems. The volume of blood products handled at Naval Hospital Great Lakes Blood Bank outgrew the capacity of the facilities at Naval Hospital Great Lakes, growing from 500 to 5,000 units per year. Additionally, Naval Hospital Great Lakes felt added pressure to expand their blood services when the Navy designated them a center of excellence for the frozen blood program (Ulnick, personal communication, April 1, 2005). At the same time, North Chicago VA Medical Center searched for a dependable source of blood supplies. Needing larger facilities and more electrical power, Naval Hospital Great Lakes found a strategic alliance with North Chicago VA Medical Center to be a logical fit.

Mission/Vision.

Under the Blood Donor Processing Center agreement Naval Hospital Great Lakes utilizes North Chicago VA Medical Center laboratory space in exchange for providing blood products via their inventory or from the stock of other blood donor centers (Department of the Navy, 15 January 2004). Additionally, the Blood Donor Processing Center fulfills potential operational requirements in support of the global war on terrorism (GWOT). While the Blood Donor Processing Center resource sharing agreement includes a purpose, a specific mission and vision are excluded from the document.

Financial Accountability.

Compared to the Inpatient Mental Health Clinic resource sharing agreement, the Blood Donor Processing Center agreement more successfully addresses reimbursement rates and projects the demand for blood services. Fiscally, the Blood Donor Processing Center follows neither the Vendor based nor the Zero-based model of accounting. Reimbursement rates for blood products depend on the Healthcare Procedural Coding System (HCPCS II) codes and Current Procedural Terminology (CPT) codes and their negotiated rates in the VISN-12 blood contract and the CHAMPUS Maximum Allowable Charges (CMAC) minus 10%, respectively. Providing an estimated \$46,831.40 of blood products and services annually, Naval Hospital Great Lakes will capture their workload via the Composite Health Care System (CHCS) and Defense Blood Standard System (DBSS) computer systems. Table 2 lists the blood products, projected volume, and the reimbursement rate per unit.

Table 2

Annual Cost of Blood Products and Services for Blood Donor Center

HCPCS/CPT	Description	Quantity	Price/Unit	Estimate (FY04) Cost/Year
P9021	Packed Red Blood Cells (pRBC)	260	\$145.00	\$37,700.00
P9059	Fresh Frozen Plasma (FFP)	140	\$55.00	\$7,700.00
P9012	Cryoprecipitate AHF	15	\$50.00	\$750.00
86890	Autologous Blood Process	Unknown ^a	\$121.44	\$0.00
99195	Therapeutic Phlebotomy	40	\$17.05	\$682.00
				Total \$46,832.00

Note. Unknown^a= Autologous blood processing currently not needed by North Chicago VA Medical Center but will required when future surgical services are offered. From North Chicago VA Medical Center and Naval Hospital Great Lakes, *VA/DoD Resource Sharing Agreement for Blood Bank/Blood Donor Processing Center*, August 31, 2004.

Aside from an annual review of blood product rates, no other means of financial accountability are provided in the resource sharing agreement. However, both organizations have designated timelines to provide funding documents, review, and reconcile charges for their exchanged services. At the end of each fiscal year, unlike the former Zero-based model, North Chicago VA Medical Center and Naval Hospital Great Lakes will exchange funds in order to balance their accounts.

Facilities Maintenance.

Facilities maintenance proves contentious between North Chicago VA Medical Center and Naval Hospital Great Lakes in the Blood Donor Processing Center resource sharing agreement. Initial plans for the 3,242 square foot facility required three air conditioning units to cool the space. However, against recommendations from Naval Hospital Great Lakes, North Chicago VA Medical Center purchased only one air conditioning unit. Eventually, North Chicago VA Medical Center realized two more air conditioning units were required to keep temperatures within an adequate range for blood product usage and storage. This example demonstrates the distrust between the organizations; despite Naval Hospital Great Lakes experience handling blood products North Chicago VA Medical Center ignored their advice.

Communication.

In accordance with recommendations from the Presidential Task Force, "VA and DoD leadership need to clearly and jointly articulate what is expected as the end state of sharing and collaboration" (2003, p.18). An improvement to previous resource sharing agreements, the Blood Donor Processing Center specifically communicates the responsibilities of North Chicago VA Medical Center and Naval Hospital Great Lakes. Naval Hospital Great Lakes provides approximately 415 units (pints) of blood product annually, limited therapeutic phlebotomy, and autologous donor services once surgical procedures are offered at North Chicago VA Medical Center. The agreement gives Naval Hospital Great Lakes responsibility for the \$40,000 renovation costs, and moving expenses associated with relocating the Blood Donor Processing Center to North Chicago VA Medical Center, as well as, the calibration and maintenance of all equipment.

In exchange, North Chicago VA Medical Center provides laboratory space and pays the utilities for the Blood Donor Processing Center. Charges for blood supplies and services, approximately \$46,831.40, provided by Naval Hospital Great Lakes will roughly equal the cost of leasing the 3,242 square feet at \$14.36 a square foot. Additionally, North Chicago VA Medical Center agrees to provide staff that will monitor refrigerator and freezer alarms after normal business hours. Specific utilities, such as snow removal, pest control, waste removal and others, covered by North Chicago VA Medical Center are also cited in the resource sharing agreement.

While Naval Hospital Great Lakes will pay for the Blood Donor Processing Center renovations, North Chicago VA Medical Center holds responsibility for the management of the renovations. In order to avoid miscommunication about renovations for the Blood Donor Processing Center the resource sharing agreement lists each item

removed, installed, and connected at North Chicago VA Medical Center. North Chicago VA Medical Center also commits human resources for police and safety services.

Discussion

The Blood Bank Processing Center demonstrates a more balanced resource sharing agreement because both organizations primarily wanted to improve access to blood services. Naval Hospital Great Lakes appeared more concerned with quality, while North Chicago VA Medical Center focused on minimizing cost. In the nascent stages, the implementation of the Blood Bank Processing Center integration appears positive.

Assessing the Outcome of Resource Sharing Agreements: The Iron Triangle Theory of Healthcare Integration

The Iron Triangle Theory of Healthcare Integration posits that the difference between a positive and negative integration depends on whether: 1) it meets expected outcomes of the organization and 2) it achieves an improved balance of cost, quality, and access. In gauging the fulfillment of the two outlined objectives, this assessment considers the expected outcomes of the federal organizations determined by the results of the situational analysis and then evaluates the barriers to integration that were cited in the document reviews of the existing resource sharing agreements. From the qualitative analysis, this research determines why the resource sharing agreement was either positive or negative. Ultimately, the Iron Triangle Theory of Healthcare attempts to explain the delta between the theoretical intent of a resource sharing agreement and the actual successful implementation of the integration.

The situational analysis of the two federal organizations demonstrates that the North Chicago VA Medical Center and Naval Hospital Great Lakes seek different expected outcomes. Generally, North Chicago VA Medical Center values improvements to access and quality, whereas Naval Hospital Great Lakes focuses on cost. But these expected outcomes shift depending on the product line of the resource sharing agreement.

The Mental Health Sharing Agreement demonstrates an example of Figure 3 when both organizations focus on the same expected outcome, cost, while giving less consideration to the other outcomes, access and quality. Even though, both organizations focused on cost, their expectations opposed rather than complemented each other. The

VA sought revenue building, while the Navy looked for cost savings. The lack of financial accountability and patient specific goals demonstrates the secondary consideration given to quality and access. Hence, a negative integration resulted because the expected outcomes were not achieved by the resource sharing agreement and created an imbalance of cost, quality, and access.

The Blood Bank Processing Center demonstrates a more balanced resource sharing agreement because both organizations primarily wanted to improve access to blood services. Naval Hospital Great Lakes appeared more concerned with quality, while North Chicago VA Medical Center focused on minimizing cost. Although recently implemented, the attention to financial accountability, organizational ethics, culture, communication, governance, leadership, and specific goals has resulted in a positive integration.

The resource sharing agreements are “laboratories for formal collaboration policy framework development” (Presidential Task Force, 2003, p.7). Valuable lessons are learned from recognizing barriers to the implementation of the past resource sharing agreements. The following paragraphs address the obstacles that prevented North Chicago VA Medical Center from achieving their expected outcomes and the overall improved balance of cost, quality, and access. North Chicago VA Medical Center and Naval Hospital Great Lakes must address the following seven themes in order to promote the success of future resource sharing agreements defined by the constructs of the Iron Triangle Theory of Healthcare Integration:

Control vs. Ownership

Over a continuum of types of strategic alliances that vary in their degree of commitment and control resource sharing agreements demonstrate more commitment and more system control because they are contractual (DeVries, 1978). Still, ownership does not equal control. As seen in the mental health agreement, North Chicago VA Medical Center maintained ownership of the facilities and staff utilized in the Inpatient Mental Health Clinic agreement, yet they exerted little control, especially over revenue generation. As a result, their expected outcomes were not fulfilled. Paramount to managing expectations of both organizations for each resource sharing agreement is determining where the locus of control will lie between North Chicago VA Medical Center or Naval Hospital Great Lakes.

Governance

A disconnect exists between the task groups that develop the resource sharing agreements and an appointed body to follow-through on implementation. To fill the void of organizational authority, work groups that develop the resource sharing agreements should evolve into the governance board that implements and maintains the integration. In developing resource sharing agreements work groups must identify a defined purpose, outline a timeframe for design implementation, and work within boundaries of authority (Leatt, Shortell, & Kimberly, 2000). Tasks of the governance boards would encompass: resolving disputes, enforcing accountability, and providing infrastructure to manage the risk. Lacking a single chain of command can cause unforeseen problems. Josh Nemzoff, a former hospital chain executive and now a merger consultant, reflects "The only thing worse than one side being in control is no one being in control. No one is vested to make

decisions” (Lumsdon, 1996). A governance board acts as a steward for the two federal organizations and maintains the integration amidst environmental forces.

Acting on behalf of North Chicago VA Medical Center and North Chicago Great Lakes, the governance board can mold the resource sharing agreement to adapt to the changing surroundings. The necessity to adapt the resource sharing agreements is inevitable, “the organization design is an ongoing process in which the design needs will change as the organization’s needs change” (Leatt, Shortell, & Kimberly, 2000, p.277). Since, a resource sharing agreement cannot address all potential issues, the governance board can scan, monitor, forecast and assess potential opportunities and threats to the integration.

Leadership

Along with governance, North Chicago VA Medical Center and Naval Hospital Great Lakes need to reassess the leadership driving the implementation of the resource sharing agreements. “There must be clear commitment from top leadership. These leaders must establish organizational cultures and mechanisms that support collaboration, improve sharing, and coordinate the management and oversight of healthcare resources and services, with clear accountability for results” (Presidential Task Force, 2003, p. 6). Capable leadership can mesh the two cultures while maintaining the integrity of their separate organizations.

The situational analysis points out differences in leadership mantras between North Chicago VA Medical Center and Naval Hospital Great Lakes resulting from organizational structure, length of staff employment, and professional acumen of staff. The formation of joint committees, like the DoD/VA Joint Executive Council formed in

January 2002, alleviates these differences but their efforts are pointless if local leaders are not committed to joint collaboration (Presidential Task Force, 2003). Implementing performance standards tied to successful integrations is one method the Presidential Task Force suggested to motivate leaders at the VISN and DoD health service region level.

Measuring Subtle Success

In the past, integration of North Chicago VA Medical Center and Naval Hospital Great Lakes often failed because few benchmarks existed to measure progress and/or the achievement of goals. The Presidential Task Force comments on the failure of past resource sharing agreements stating that they "have not been successful in establishing and institutionalizing common purposes and goals creating measurements with common indices to monitor progress, demanding accountability, and promoting effective collaboration through incentives and other mechanisms" (Presidential Task Force, 2003, p. 14). The Inpatient Mental Health Clinic resource sharing agreement demonstrated that a lack of specific goals and accountability standards can lead to a negative integration.

Improvements to quality, as an outcome of integration, are slower to manifest than improvements to cost or access. Similarly, success measured by innovation or organizational learning is more subjectively discerned than success measured by financial gains. The Presidential Task Force explains success is not based on the bottom line, "Success lies not in maximizing the number or dollar value of sharing agreements, but in implementing arrangements that result in the most cost-effective and timely delivery of quality care" (2003, p.16). Ideally, by definition of integration, a successful resource sharing agreement achieves economies of scale while meeting the needs of DoD/VA beneficiaries, but also it provides learning environments for both organizations, and

fulfills the growth strategies of both federal facilities. As stated in the literature review, while improvements to cost are most evident, if specific goals are established success of integration can be determined in terms of access and quality.

Voluntary vs. Mandated

While the resource sharing agreements seem ad-hoc, and voluntarily proposed; most collaboration results from political pressure. North Chicago VA Medical Center and Naval Hospital Great Lakes form resource sharing agreements as a result of a government mandate, the 1983 Sharing Act, to strategically align DoD and VA resources. This historical note explains much of the strife and “bad blood” between North Chicago VA Medical Center and Naval Hospital Great Lakes. Explicatives like “We’re in this mess because of the Navy/ VA...” are commonly lobbed at opposing members during work group or even Executive Steering Council meetings. Scott (1987) explains this reaction when he states, “Mandated forms of organization [integration] tend to be adopted only superficially and, as a result, also tend to be short-lived” (p. 495). In previous resource sharing agreements, both organizations resisted integration with passive aggressive gestures to sabotage the integration (Ulnick, personal communication, April 4, 2005; Manzcko, personal communication, April 6, 2005). Despite political mandate to cooperate, to ensure the success of future resource sharing agreements both organizations should embrace each other as if they volunteered to integrate.

Developing Common Standards

Without standardization between North Chicago VA Medical Center and Naval Hospital Great Lakes tasks from the credentialing of surgeons to the simple electronic exchange of patient encounters will pose an imposition to future integration.

Interoperable, interchangeable program elements, as well as, compatible information management and technology will result in increased efficiency, cost savings, and improves access for DoD and VA patients (Presidential Task Force, 2003). To develop common standards, the Presidential Task Force cites that the two federal organizations need to: “develop a coordinated budget and execution strategy for collaboration.” A joint budget and execution strategy would facilitate the communication of cost expectations, and standards for quality and access. Second, the Task Force recommends “eliminating policy and program barrier between VA and DoD.” Standardization will eliminate barriers to integration such as disagreements about the reimbursement rate for mental health patients in the Inpatient Mental Health Clinic. Finally, the Task Force recommends “institutionalizing processes that ensure collaboration and communication.” In order to institutionalize the “collaboration process” or the development of resource sharing agreements, North Chicago VA Medical Center and Naval Hospital Great Lakes must conduct a situational analysis of their organizations, review lessons learned from past resource sharing agreements, and, finally, follow certain themes to ensure successful integration—the embodiment of this research.

Managing Expected Outcomes

As cited in the literature review, a common vision is paramount to ensure fulfillment of expected outcomes. In the Inpatient Mental Health Clinic agreement North Chicago VA Medical Center expected revenue enhancement while Naval Hospital Great Lakes aimed for cost reduction. With different objectives, this agreement inevitably waned because “there are differences in the challenges for success for alliances, in how one gauges success, and in how cost reducing versus revenue enhancing alliances might

be organized” (Zajac, D’Aunno, & Burns, 2000, p. 315). One method to managing expected outcomes is using a multidisciplinary approach to brainstorm any potential barriers to implementation of the integration. For example, the development of the Blood Donor Processing Center should have gathered input from a nurse, a physician, a laboratory technician, a hematologist, and other health workers from both North Chicago VA Medical Center and Naval Hospital Great Lakes. In this manner, all key players buy into seeing the resource sharing agreement successfully implemented, while minimizing the impact of infectious naysayers.

Conclusion

Both the Executive and Legislative branches of the United States envision North Chicago VA Medical Center and Naval Hospital Great Lakes forming successful resource sharing agreements that improve the cost, quality, and access of healthcare to Veteran and DoD beneficiaries, "It is essential to note that the overall goal of collaboration is to improve the timely delivery [access] of high quality healthcare to the beneficiaries of the two Departments by working together in a cost-effective manner" (Presidential Task Force, 2003, p. 18). As the demands on military forces increase and military healthcare systems feel the economic pressure of rising medical costs and an aging population, successful integration between these two organizations is paramount to providing healthcare to DoD and VA beneficiaries.

The situational analysis of North Chicago VA Medical Center and Naval Hospital Great Lakes provided an understanding of these healthcare organizations' motivation to form a strategic alliance. The document review recognized the barriers that led to the negative implementation of the Inpatient Mental Health Clinic and the more positive implementation of the Blood Bank/Blood Donor Processing Center. Finally, the Iron Triangle Theory of Healthcare Integration establishes the difference between North Chicago VA Medical Center and Naval Hospital Great Lakes' theory of a resource sharing agreement and the successful implementation of their integration hinges on the following: agreeing on the locus of control/ownership, governance, leadership, approaching a mandate as if it were voluntary, developing common standards, managing expected outcomes, and measuring subtle success. Consequently, future resource sharing

should focus on these areas in order to avoid disappointing outcomes, and increase the quality of care and access to care, while diminishing the cost for the partnering organizations. Improvements to the Alliance Process now, as demonstrated in current resource sharing agreement implementation, between North Chicago VA Medical Center and Naval Hospital Great Lakes will ensure the future success of the Federal Ambulatory Care Clinic.

References

- Arthur, D. Surgeon General's Top Five Priorities. Retrieved April 15, 2005, from <http://navymedicine.med.navy.mil/bumed/index.cfm?docid=14373>
- Bradford, R. W. & Duncan, J.P. (2000). *Simplified Strategic Planning: A No-Nonsense Guide for Busy People Who Want Results Fast!* Worcester, MA: Chandler House Press.
- Report of the Commission on the Future Structure of Veterans Health Care. (1991).
- Legal Information Institute. US Code Collection. Retrieved May 10, 2005 from http://straylight.law.cornell.edu/uscode/html/uscode10/usc_sec_10_00001074----000-.html
- Department of Justice. Executive Summary on Healthcare. Retrieved April 2, 2005, from http://www.usdoj.gov/atr/public/health_care/204694/exec_sum.htm#N2
- Department of Veterans Affairs. Capital Asset Realignment for Enhanced Services (CARES). May 7, 2004 CH 5 SDO. Retrieved February 3, 2005, from <http://www.va.gov/CARES/>
- Department of Veterans Affairs. MCHO-CL-MPR Information Paper.. 10 October 2002.
- DeVries, R. (1978). Strength in numbers. *Hospitals: Journal of the American Hospital Association*, 55, 81-84.
- Eberhart, J. Merger failure: A five-year journey examined. *Healthcare Financial Management*. 55 (4) April 2001.
- Emery, F. & Trist, E. (1965). The casual texture of organizational environments. *Human Relations* 18: 21-32.
- Galloro, V. & Evans, M. The surge to merge. *Modern Healthcare*. January 24, 2005

- Ginter, P. M., Swayne, L. E., & Duncan, W. J. (1998). *Strategic Management of Healthcare Organizations*. Malden, MA: Blackwell Publishers, Inc.
- Hansen, R. D. (2003). Strategic planning: It's worth the effort. *Medical Group Management Association Connexion*. September 2003, 36-39.
- Harrigan, K. (1985). *Managing for Joint Venture Success*. Lexington, MA: Lexington Books.
- Hoffman, P. Hospital mergers and acquisitions: A new catalyst for examining organizational ethics. *Bioethics Forum*. Summer 1996.
- Humana Military Healthcare Services. (2005). Retrieved May 3, 2005, from <http://www.humana-military.com/south/provider/TRICAREResources/Handbook/ProvHndbkS9P1.htm>
- Kaluzny, A., Morrissey, J., & McKinney, M. (1990). Emerging organizational networks: The case of the community clinic oncology program. In S. Mick & Associates (Eds.), *Innovation in health care delivery*. San Francisco, CA: Jossey Bass.
- Kaluzny A., Zuckerman, H. & Ricketts, T. (1995). *Partners for the dance: Forming strategic alliances in healthcare*. Ann Arbor, MI: Health Administration Press.
- Kirk, M. (2001). Working to Enhance Support for Veterans. The United States House of Representatives. Retrieved April 15, 2005, from <http://www.house.gov/kirk/veterans.htm>
- Kissick, W. (1994). Medicine's Dilemmas: Infinite Needs Versus Finite Resources

Lafrance, K. (2003) personal communication The Nature of Strategic Management.

Septemer 3, 2003.

Lumsdon, K. Deals that went down the drain. *Hospitals and Health Networks*. (70)

(1996).

Macneil, J. R. (1983). Values in contract: Internal and external. *Northwestern University*

Law Review, 78, 340-418.

Meyer, A. (1982). Adapting to environmental jolts. *Administrative Science Quarterly*,

27, 515-537.

Military Managed Healthcare System (M2). Version 3.2. [Data file]. Great Lakes,

Chicago: Great Lakes Naval Hospital.

North Chicago VA Medical Center and Naval Hospital Great Lakes, *VA/DoD Resource*

Sharing Agreement for Blood Bank/Blood Donor Processing Center. August 31,

2004

North Chicago Veterans Affairs Medical Center and Naval Hospital Great Lakes.

VA/DoD Resource Sharing Agreement for Psychiatric Inpatient and Medical

Hold. November 28, 2004 to August 31, 2008.

Naval Hospital Great Lakes Web page. Important Information, Strategic Plan. Retrieved

from <https://nhglweb/> on April 12, 2005.

News Release, VA Takes a major step in National CARES Planning Process.

Department of Veterans Affairs, August 4, 2003

Pearce, J. (1982, Spring). The company mission as a strategic tool. *Sloan Management*

Review, 23(3), 15-24.

- Pesnell, M. (2004). *A regional strategic human resources plan for hospitals and health systems in south and central Texas*. Unpublished master's thesis, Army-Baylor University, San Antonio, Texas.
- Prahalad & Hamel (1990, May-June). The core competence of the corporation. *Harvard Business Review*, 68(3), 79-82.
- Presidential Task Force. *Presidential task force to improve health care delivery for our nation's veterans*. Final Report. May 2003.
- Scott, W. (1987). The adolescence of institutional theory. *Administrative Science Quarterly*, 32, 493-511.
- Shi, L. & Singh, D. *Delivering Healthcare in America*. 2nd edition. Aspen Publication. Gaithersburg, Maryland. 2001.
- Shortell, S.M. (1988). The evolution of hospital systems: Unfulfilled promises and self-fulfilling prophecies. *Medical Care Review*, (45)2, 177-214.
- Shortell, S. M. & Kaluzny, A. D. (2000) *Healthcare Management: Organizational Design and Behavior*, 4th Ed. Albany, NY: Delmar, Thomson Learning.
- Taylor, M. Finally. *Modern Healthcare*. January 24, 2005
- Thompson, J. T. (1967). *Organizations in Action*. New York: McGraw Hill.
- Zajac, D'Aunno, & Burns, 2000 (chapter in a book) *Managing Strategic Alliances*. Healthcare Management: Organizational Design and Behavior.
- Zajac, E. J., Golden, B. R., & Shortell, S. M. (1991). New organizational forms for enhancing innovation: The case of internal corporate joint ventures. *Management Science*, 37, 70-184.
- Zuckerman, H. & D'Aunno, T. (1990).

Zuckerman, A. & Spallina, J. (2001). Integration of hospitals, services is more complex than consolidation. *Healthcare Strategic Management*.

Annex 1

Questionnaire on Resource Sharing Agreement between North Chicago Veterans Association Medical Center (NCVAMC) and Naval Hospital Great Lakes (NHGL)

Note: For the purposes of this questionnaire Inter-Service Sharing Agreements (ISSA) are called Resource Sharing Agreements

Organization of Employment: NCVAMC NHGL
(Please circle one answer)

Number of years with organization _____

Rank or Government Service grade _____

How many years have you played an active role in NCVAMC/ NHGL resource sharing agreements?

Based on your knowledge of the mission of NHGL, which concept(s) is most important to the institution? (Please circle no more than two answers).

Cost Quality Access

From experience working with NHGL, which concept(s) is actually focused on in daily clinical practice? (Please circle no more than two answers).

Access Cost Quality

Based on your knowledge of the mission of NCVAMC, which concept(s) is most important to the institution? (Please circle no more than two answers).

Quality Access Cost

From experience working with NHGL, which concept(s) is actually focused on in daily clinical practice? (Please circle no more than two answers.)

Access Quality Cost

What vision drives the formation and implementation of Resource Sharing Agreements?

From your standpoint, which concept(s) is the driving force in the formation of Resource Sharing Agreements: (Please circle no more than two answers.)

For the NCVAMC? Cost Access Quality

For the NHGL? Quality Cost Access

Please describe the organizational cultures of the following organizations:

NCVAMC?

NHGL?

Strengths, Weaknesses, Opportunities, Threats (SWOT)

In your opinion, what are two or three most compelling strengths of the:

NCVAMC:

NHGL:

Resource Sharing Agreements:

In your opinion, what are two or three most compelling weaknesses of the:

NCVAMC:

NHGL:

Resource Sharing Agreements:

In your opinion, what are two or three most compelling opportunities of the:

NCVAMC:

NHGL:

Resource Sharing Agreements:

In your opinion, what are two or three most compelling threats of the:

NCVAMC:

NHGL:

Resource Sharing Agreements: